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DRAFT INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOL FOR CONTRACT YEAR 2008

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Introduction

Medicare Advantage organizations (and organizations offering Social HMOs) must submit a separate bid for each plan they offer to Medicare beneficiaries. In the case of a local plan with service area segments, a separate bid must be submitted for each segment.

The bid must be submitted to the Centers for Medicare & Medicaid Services (CMS) on the provided form – the Medicare Advantage (MA) Bid Pricing Tool (BPT). The MA bid form should not be completed for Medical Savings Account (MSA), Cost, and PACE plans. There is a separate bid pricing tool for MSA plans.

Additionally, MA organizations (MAO) must give CMS supporting documentation as described throughout these instructions and in the Supporting Documentation appendix. The submitted bids will be subject to review and negotiation by CMS. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

If the plan includes prescription drug benefits under the Medicare Part D program, then an *additional Rx bid form* must be completed and submitted.

To complete the MA bid form, organizations must provide a series of data entries on the appropriate form pages. The number of inputs depends on the type of plan and how long it has operated, among other factors.

Following are the most common steps that an MA organization with fully credible experience data must complete:

- Report the Medicare base period allowed costs.
- Enter the estimated adjustments needed to project the base period costs to the contract year (CY).
- Report the estimated cost sharing values for the contract year.
- Enter the projected CY non-benefit expenses and gain/loss margin.
- Enter the projected enrollment and risk scores by county.
- Allocate rebates (if any).

MA organizations that do not have base period costs, or do not have fully credible experience, must enter a manual rate that estimates the medical costs for the contract year.

MAOs must use the bid pricing tool to develop a pricing structure for each MA plan/segment. Organizations must submit the information in the CMS-approved electronic format via the CMS Health Plan Management System (HPMS).

Appendix C contains further information regarding MA plans covering Part B-only enrollees. Appendix D provides information for “group bids” (i.e., employer groups and union groups). Appendix E contains additional guidance regarding MA plans covering Qualified Medicaid Beneficiaries (QMBs).

Note: Any data entries included in the bid form are for illustration purposes only.

In addition to these instructions, information regarding CY2008 bidding may be found at the following resources:

- The **CY2008 Final MA/MA-PD Call Letter** contains information and guidance pertaining to CY2008 bidding, and may be found at http://www.cms.hhs.gov

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

- CMS Office of the Actuary will host weekly **actuarial technical user group calls** regarding actuarial aspects of the CY2008 bidding process. The conference calls will include live Question & Answer sessions for participants to speak with CMS actuaries. For call information, please contact OACT at the e-mail address above.

- If there are any **technical questions** regarding the BPT, HPMS, or the upload process, refer to the following resources:

    - Appendices H and I of these instructions.

    - The "Bid Submission User's Manual" (available in HPMS).

    - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov .

General Overview

These instructions provide guidance in completing the Medicare Advantage Bid Pricing Tool.

The MA bid form is organized as outlined below:

Worksheet 1 - MA Base Period Experience and Projection Assumptions
Worksheet 2 - MA Projected Allowed Costs PMPM
Worksheet 3 - MA Projected Cost Sharing PMPM
Worksheet 4 - MA Projected Revenue Requirement PMPM
Worksheet 5 - MA Benchmark PMPM
Worksheet 6 - MA Bid Summary
Worksheet 7 - Optional Supplemental Benefits

All worksheets must be completed, with the following exception: if the plan does not offer any optional supplemental benefit packages, then Worksheet 7 should be left blank.

In addition, each organization must complete the Two-Year Look-Back form, unless it did not have any Medicare experience in 2006 (i.e., if the organization did not file any CY2006 MA BPTs).

If the plan includes prescription drug benefits under the Medicare Part D program, then an *additional Rx bid form* must be completed. The separate Rx bid pricing tool captures information regarding any prescription drug benefits offered by the plan. While the supplemental benefits (either prescription drug or A/B) offered by the plan may be viewed as a single package, the two types of supplemental benefits are considered separately for bidding purposes.

The following sections explain how to complete the MA bid form and include line-by-line instructions with user inputs noted. In addition, there is a glossary to assist the user with unfamiliar terms. The Medicare Benefit Description Report available the Health Plan Management System (HPMS) may also be helpful.

Some of the material changes in the CY2008 bid form and instructions (as compared to CY2007) are highlighted below. These changes were a result of feedback received from industry and were made in an effort to increase the usability/functionality of the BPT.

- Part D Basic Premium (reported on MA BPT Worksheet 6 cell R34, but calculated in the Part D BPT) may be a negative number. In the CY2007 MA BPT, there was an erroneous validation such that negative Part D Basic premiums were prohibited. This has been corrected in the CY2008 MA BPT.
- Certain sections of the MA BPT were removed, as they were deemed no longer necessary. These sections include: MA BPT Worksheet 5 Sections VII and VIII (which summarized demographic information for some demonstration plans in the CY2007 MA BPT) and MA BPT Worksheet 6 Sections V and VI (which contained RPPO risk sharing information in the CY2007 MA BPT).

Rounding must not be used when entering data into the bid form, except for rebate allocations on Worksheet 6 (see instructions).

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

Note: Any data entries included in the bid form are for illustration purposes only.

Worksheet 1 - MA Base Period Experience and Projection Assumptions

This worksheet summarizes the base period data and the key assumptions used to calculate the projected allowed costs for the contract period. Section I contains general plan information that will be displayed on all MA worksheets. Section II captures base period background information. Section III summarizes the base period data, and Section IV illustrates the factors used to project the base period data to the contract period.

All information provided on Worksheet 1 must exclude ESRD enrollees.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- A reconciliation of base period experience with company financial data.
- Support for projection assumptions.
- Information about "actuarial swapping" or the "actuarial equivalence" category of customization allowable for employer and union groups, as described in Appendix D.
- Information regarding the member month distribution if more than four plans comprise the base period data (see Section II line 5).

SECTION I - GENERAL INFORMATION

The fields of Section I have been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, numeric fields, such as Plan ID, Segment ID and Region Number, must be entered as text (i.e., 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 PPO plan), or E (Employer/Union Direct Contract Private FFS plan) and includes four Arabic numerals (e.g., H9999, R9999, E9999). Be sure to include all leading zeros (e.g., H001, H0123).

Line 2 – Plan ID. The plan ID (accompanied by the corresponding contract number) forms a unique identifier for the plan benefit package being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '001).

If the bid is for a plan that is offered only to employer or union groups, then the plan ID will be 800 or higher. These plans may be referred to as an "800-series plan", a "group plan", an "employer/union-only group waiver plan (EGWP)", or an "employer-only group plan".

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 (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '01).

Line 4 – Contract Year. This 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 the PBP.

Line 6 – Plan Name. Enter the plan name of the plan benefit package that corresponds to the information contained in this bid pricing tool. This information also appears in HPMS and the PBP.

Line 7 – Plan Type. Enter the type of MA plan. The valid options are listed in the table below.

The MA bid form should not be completed for MSA, Cost, and PACE plans. There is a separate MSA Bid Pricing Tool.

Note that an MAO must offer at least one benefit plan (of any plan type) that includes Part D coverage for each service area. This requirement does not apply to PFFS plans, which can be offered in a service area without Part D coverage.

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization	HMO
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS
Provider-Sponsored Organization w/State License	PSO State License
Provider-Sponsored Organization w/Federal Waiver of State License	PSO Federal Waiver
Preferred Provider Organization	LPPO
Regional Coordinated Care Plans:	
Regional Preferred Provider Organization	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service	PFFS
Employer/Union Direct Contract Private Fee-for-Service Plans:	
Employer/Union Direct Contract Private Fee-for-Service	ED PFFS
Demonstration Plans:	
Continuing Care Retirement Community	CCRC
Social HMO	SHMO
Minnesota Disability Health Options	MN DHO
Minnesota Senior Health Options	MN SHO
Wisconsin Partnership Program	WI PP
Massachusetts Health Senior Care Options	MA HSCO

Line 8 – MA-PD Indicator. If the plan is offering Part D benefits during the contract year (and therefore is submitting a separate Rx bid form for the same plan ID), enter "Y". Otherwise, enter "N".

Line 9 – Enrollee Type. If the bid prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, enter "A/B". If the bid prices any type of plan covering enrollees eligible for Part B only, enter "Part B Only". (See Appendix C for additional information regarding Part B only plans.)

Line 10 – MA Region. If the MA plan is a regional PPO (i.e., plan type = RPPO), then input the region number associated with the region that the plan will cover. This field must be entered as a text input (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '01).

For regional PPO plans, valid entries are as follows:

Region	Description
01	Northern New England (New Hampshire and Maine)
02	Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont)
03	New York
04	New Jersey
05	Mid-Atlantic (Delaware, District of Columbia, and Maryland)
06	Pennsylvania and West Virginia
07	North Carolina and Virginia
08	Georgia and South Carolina
09	Florida
10	Alabama and Tennessee
11	Michigan
12	Ohio
13	Indiana and Kentucky
14	Illinois and Wisconsin
15	Arkansas and Missouri
16	Louisiana and Mississippi
17	Texas
18	Kansas and Oklahoma
19	Upper Midwest and Northern Plains (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming)
20	Colorado and New Mexico
21	Arizona
22	Nevada
23	Northwest (Idaho, Oregon, Utah, and Washington)
24	California
25	Hawaii
26	Alaska

Line 11 – Actuarial Swap or Equivalences. If an individual-market plan will use actuarial swaps or equivalences for employer or union groups, enter "Y". Otherwise, enter "N". See Appendices B and D for further information on using swaps or equivalences.

Line 12 – SNP Indicator. If the plan is a Special Needs Plan (SNP), enter "Y". Otherwise, enter "N".

Line 13 – Region Name. No user input is required. This field contains the region name, based on the region number entered previously in this section.

Line 14 – Percentage of Contract Year Enrollees that are Dually Eligible. Enter the percentage of projected enrollees that are dually eligible, i.e. eligible for both Medicare and Medicaid, during the contract period.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition. Enter the incurral dates of the base period data on the first two lines and the "paid through" date on the third line.

For example, if the incurral period is calendar year 2006, the "incurred from" date is 1/1/2006 and the "incurred to" date is 12/31/2006. If the data reflect payment information through February 2007, the "paid through" date is 2/28/2007.

While we generally expect the experience data to be based on a 12-month incurral period with at least 30 days paid run-out (e.g., 2 - 3 months of paid claim run-out), we do not require that the base experience incurral period be a *calendar* year.

CMS recommends that plans should not rely solely on CY2007 year-to-date claims experience for the CY2008 projection.

When selecting base period data, the certifying actuary should consider ASOP No. 8, with particular attention to the section *Use of Past Experience to Project Future Results*. The certifying actuary should also consider ASOP No. 23, with particular attention to the sections *Selection of Data* and *Use of Imperfect Data*.

If credible and appropriate base period data are available, CMS expects these data to be reported in Worksheet 1 of the bid form and used to project plan costs. The certifying actuary must rely on his/her professional judgment to determine what is considered credible and appropriate data.

Line 2 – Member Months (excluding ESRD). Enter the total member months represented in the base period experience, excluding ESRD enrollees.

Line 3 – Non-ESRD Risk Score. Enter the plan's risk score, as of the mid-point of the period, underlying the base period data. The 100% HCC risk score for non-ESRD members must be used.

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. The factor entered must be the amount to adjust only the portion of paid claims that requires completion (i.e., omit capitations from the calculation of this factor).

For example, assume:

Incurred Date	1/1/2006 – 12/31/2006
Paid Through Date	2/28/2007
Capitation Payments	$100
PTD Claims Requiring Completion	$400
Estimate of Unpaid 2006 Claims as of 2/28/2007	$30
Total Incurred Claims for 2006	$530

The Completion Factor would be calculated as:
Completion Factor = (400 + 30) ÷ 400 = 1.075

Line 5 – Plans Included in Base Period Data. Enter the contract number and plan ID (in the format H9999-999) of the plans that are included in the base period data. In the second column, input each plan's percentage of the total member months reported in Line 2.

Plan IDs should be reported in descending order of member months, such that the plan with the largest percentage of member months is listed first. For example:

5. Plans in Base	Contract-Plan ID	% of Member Months
	a. H9999-032	44%
	b. H9999-001	37%
	c. H9999-002	19%
	d.	

If more than four plans comprise the base period data, then the plan must submit supporting documentation that provides the percentage of base period member months for each plan included in the base period data. In this situation, plans may enter "All Other" for the Contract-Plan ID indicated in Line 5d

Line 6 – Base Period Description. Use the text box provided to briefly describe the base period data. The base period data need not reflect the same benefit plan or service area as the contract year. Do not adjust base period data for credibility, as this issue is addressed on Worksheet 2 with manual rates. Following are examples of different base period data:

- Same benefit plan, but larger or smaller service area.
- Same benefit plan, but an entirely different service area.
- Similar benefit plan in same or different service area.
- Benefit plan with similar in-network benefits/cost sharing.

SECTION III – BASE PERIOD DATA (AT PLAN'S NON-ESRD RISK FACTOR)

Section III summarizes the base period data by benefit service category.

General Considerations.

CMS recommends that plans should not rely solely on CY2007 year-to-date claims experience for the CY2008 projection. While we generally expect the experience data to be based on a 12-month incurral period with at least 30 days paid run-out (e.g., 2 - 3 months of paid claim run-out), we do not require that the base experience incurral period be a *calendar* year.

When selecting base period data, the actuary should consider ASOP No. 8, with particular attention to the section *Use of Past Experience to Project Future Results*. The actuary should also consider ASOP No. 23, with particular attention to the sections *Selection of Data* and *Use of Imperfect Data*.

If credible and appropriate base period data are available, CMS expects these data to be reported in Worksheet 1 of the bid form and used to project plan costs. The certifying actuary must rely on his/her professional judgment to determine what is considered credible and appropriate data.

Note that these data:

- Need *not* exactly match the benefit plan or service area for the bid (see Section II instructions). Section IV will address adjusting the base period data to the contract year benefit plan and service area.
- Reflect either calendar year or other *annualized* experience.
- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Include any provider incentive payments.
- Include total services (both in-network and out-of-network, Medicare-Covered and additional services).
- Reflect costs before any reduction for member cost sharing and reinsurance recoveries (i.e., the experience data must be on an *allowable* basis).
- Include capitations allocated to the appropriate service category line on a reasonable basis.
- Exclude ESRD claim experience.

Appendix G contains a suggested **mapping of benefit categories** between the PBP software and the bid pricing tool. The Medicare Managed Care Manual may also be a helpful resource regarding benefit definitions:
http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326

Service category lines can be one of three types:

- Medicare-Covered services that may be supplemented, as an A/B Mandatory Supplemental Benefit, (e.g., the cost for additional days not covered by Medicare in line a, Inpatient Facility).
- Services that can only be Medicare-Covered.
- Services that can only be Non-Covered (e.g. line l, Transportation).

The benefit costs will be distributed between Medicare-Covered and Non-Covered benefits based on the percentages entered in Worksheet 4 columns h and i.

POS experience data may be included in the appropriate service category (in lines a through o and q through s), with nothing entered in the POS service category (line p). Alternatively, the plan may enter the POS experience in line p.

For **Non-Covered limited benefits with no cost sharing**, the amounts over the limit should not be included as allowed costs in the bid form.

> Example: The PBP contains a hearing aid benefit with a $500 annual cost limit and no cost sharing. If the average cost of a hearing aid is $2,500, the allowed PMPM in column i should be based on the $500 maximum benefit, not on a $2,500 cost offset by a cost sharing entry in Worksheet 3 for the $2,000 paid by the beneficiary.

The **COB/Subrogation** line (line s) is intended to include only those amounts settled outside the claim system. If an MAO pays claims for its estimated liability only (i.e., net of the amount that is the responsibility of another payer, such as an employer plan or auto policy), the MAO's net liability amount (before cost sharing reductions) may be entered on lines a through r. [This is a change from the ACR instructions, in which the detail service claims were to be reported at the full amount (i.e., including other payer liabilities) and the full COB amount used. Both methods result in the same total allowed cost across all service categories.]

See **Appendix B** for information regarding supporting documentation for base period data.

Column c, Lines a through s – Service Category. The types of benefit service categories are displayed in column c. See Appendix G for a suggested mapping of BPT and PBP service categories. For more information on benefits and service categories, see the Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections: http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326

Column f, Lines a through r – **Utilization type**. The type of utilization *must* be entered in column f. Do not leave this column blank. If the plan is not using base period experience data, but instead is using manual rates, entries in this column are still required.

For each service category line, enter the appropriate utilization type that reflects the annualized utilization/1000 enrollees entered in column g. The valid utilization types are listed below. Note that the valid utilization types vary by service category.

- A – Admits
- D – Days
- BP – Benefit Period
- V – Visits
- P - Procedures
- T – Trips
- S – Scripts
- O - Other

Column g, Lines a through r – **Annualized Utilization/1,000.** Enter the annualized utilization per thousand enrollees for each of the benefit service categories for the base period data. The utilization/1000 must be reported consistently with the utilization type entered in column f.

Column h, Lines a through r – **Average Cost.** These cells are calculated using the utilization provided in column g and allowed PMPM provided in column i.

Column i, Lines a through s – **Allowed PMPM**. Enter the allowed PMPM by service category for the base period. Note that line s will be *added* to total medical expenses; thus any COB/Subrogation offsets to costs must be input as a negative number.

Line t – Total Medical Expenses. Calculated as the sum of lines a through s.

Line u – Subtotal Medicare-Covered service categories. Calculated as the sum of lines a through k.

SECTION IV – PROJECTION ASSUMPTIONS (COLUMNS J THROUGH P)

Section IV presents the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The factors in columns j through n are the *total* adjustment factor from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2006 and that the contract year is 2008. If the utilization trend is 5% from 2006 to 2007 and 6% for projecting 2007 to 2008, then enter 1.113 in column j (1.05 x 1.06).

See Appendix B for information regarding supporting documentation for projection assumptions.

Column j, Lines a through s – **Util/1000 Trend**. Enter the total expected utilization trend factor from the base period to the contract period by service category. (Entering 1.000 would indicate 0%.) Do not leave blank.

Column k, Lines a through s – **Benefit Plan Change**. Enter the multiplicative adjustment factor for any benefit plan changes that affect the base period utilization by service category (e.g., increase in coverage level from base period to contract period). (Entering 1.000 would indicate 0%.) Do not leave blank.

Column l, Lines a through s – **Population Change**. Enter any expected demographic or morbidity changes that are necessary to adjust the base period data to the contract period. (Entering 1.000 would indicate 0%.) Do not leave blank.

Column m, Lines a through s – **Other Factor**. Enter any other utilization factor adjustments by service category. Describe the reason for any adjustments in Section V if a factor other than 1.000 is used. Examples of the use of this factor are to adjust the base period service area to the contract year service area or to adjust consolidated base period experience to a specific plan option. (Entering 1.000 would indicate 0%.) Do not leave blank.

Column n, Lines a through s – **Unit Cost/Intensity Trend**. Enter the unit cost/intensity trend by service category. This factor must reflect the anticipated unit cost/intensity trend from the base period to the contract period. (Entering 1.000 would indicate 0%.) Do not leave blank.

Columns o and p, Lines a through s – **Additive Adjustments**. Use these columns to reflect adjustments that are additive (adjustments in columns j through n are multiplicative factors). For example, a benefit that is no longer being offered, but is included in the base period data, might need to be deleted/removed. In this case, enter the projected PMPM of the benefit being removed as a negative number in column p. For benefits that need to be added, if they are not included in the base period experience data but will be offered in the contract period, the plan should utilize the manual rates section of Worksheet 2.

Do not input an additive utilization adjustment for COB (column o, line s) since there is no base period utilization for COB.

Describe the reason for any additive adjustments in Section V.

SECTION V – DESCRIPTION OF OTHER UTILIZATION FACTOR AND ADDITIVE VALUES

Use this “text box” field to describe the reason for using a multiplicative factor other than 1.00 in column m and any additive adjustments entered in columns o and p.

Worksheet 2 - MA Projected Allowed Costs PMPM

This worksheet calculates the projected allowed costs for the contract year. For plans without fully credible experience, it will be necessary to input manual rate information. The service category lines are the same as those on Worksheet 1.

All information provided on Worksheet 2 must exclude ESRD enrollees.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The manual rate development.
- Significant projected allowed costs for Non-Covered services.
- A credibility approach different from the CMS guideline described in these instructions.

SECTION I - GENERAL INFORMATION

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

SECTION II – PROJECTED ALLOWED COSTS

Plan's non-ESRD Risk Factor (for the contract period) – The non-ESRD risk factor for the contract year is obtained from Worksheet 5.

Lines a through s.

Column e – **Utilization type**. Displays the utilization types entered on Worksheet 1.

Columns f through h – Projected Experience Rate. Columns f through h are calculated using the information provided in Sections III and IV on Worksheet 1. No user inputs are needed. Column f calculates the projected utilization, column g is the expected average cost, and column h is the Allowed PMPM for the contract period, projected based on base period experience data.

Columns i through k – Manual Rate. For a plan with less than fully credible experience or no experience (see instructions for Worksheet 1 regarding base period experience data and credibility), you must enter manual rate information for the contract period. You must provide a description of the source of the manual rate in line v. The general considerations listed for the Base Period Experience data also apply here (see Worksheet 1 instructions).

Supporting documentation for the development of the manual rate is required (see Appendix B).

Utilization/1000 assumptions by service category must be entered in column i for lines a through r. The manual's utilization rates must be consistent with the "utilization type" input on Worksheet 1. *If no base period data were entered on Worksheet 1, enter the manual rate's utilization types in Worksheet 1 column f.* The utilization type column must not be left blank. Average costs (column j) will be calculated based on the entries in columns i and k. Projected PMPM amounts must be entered in column k.

Line s will be *added* to total medical expenses; thus any COB/Subrogation offsets to costs must be entered as a negative number.

Column l – Experience Credibility Percentage. Enter the experience credibility percentage by service category in column l. This percentage must be between 0% and 99% if the plan is using a manual rate in the projection. The credibility assumption may vary by service category, especially when a subset of providers is reimbursed on a capitation basis or when a new benefit category is added using a manual rate.

Based on an application of classical credibility theory to Medicare Fee-for-Service experience, CMS has established a guideline for full credibility of 24,000 base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. Note that this formula is a guideline; organizations may use a different credibility approach if appropriate supporting materials are provided (see Appendix B).

For example, if the member months reflected in the experience period were to equal 6,000, then in the projection of contract year medical expenses, the weight given to actual trended experience would equal 50 percent [calculated as (6,000/24,000)^(1/2)]. Alternatively, 100% credibility weight would be given to actual trended experience if there were 30,000 member months during the experience period.

See instructions for Worksheet 1, Section II, line 1 (base period time definition) for additional guidance on the base period used.

Columns m through o – Contract Year Rate. Columns m through o calculate the blended contract year rate, based on the projected experience rate and the manual rate. The Contract Year Rate is included in the plan's contract year revenue requirements. Supporting documentation is required for significant projected Non-Covered allowed costs (see Appendix B).

Column p – Percentage of Services Provided Out-of-Network. Enter the percentage of total allowed costs that are expected to be provided out-of-network for each service line. Completion of this section is required for PPO plans and is optional for other plan types. Enter a 0 if zero percent is expected; do not leave the field blank to indicate 0%.

Line t – Total Medical Expenses. Calculated as the sum of lines a through s.

Line u – Subtotal Medicare-Covered service categories. Calculated as the sum of lines a through k.

Line v – Manual rate description. Use the text box to provide a description of the source of the manual rate, including trend assumptions.

Worksheet 3 - MA Projected Cost Sharing PMPM

Worksheet 3 summarizes the expected MA cost sharing for the contract year and includes both in-network and out-of-network cost sharing.

All information provided on Worksheet 3 must exclude ESRD enrollees.

The cost sharing information entered on this worksheet must tie to the PBP and, as such, must contain enough detailed information to be easily cross-checked by CMS. A description of the cost sharing for each benefit category is required.

Note that although there are not individual entries for each cost sharing item listed in the PBP, the value of all cost sharing items must be reflected in the total PMPM amount on this worksheet.

Any member premium(s) and Part D cost sharing must be excluded from Worksheet 3.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The process for adjusting cost sharing due to OOP limits.
- Support for cost sharing utilization assumptions and plan level deductible.

SECTION I - GENERAL INFORMATION

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

SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

See Appendix B for information regarding required supporting documentation for out-of-pocket limits.

Line 1 - In-Network. Enter the maximum total dollar amount that a member could pay for in-network cost sharing for the contract year.

Line 2 – Out-of-Network. Enter the maximum total dollar amount that a member could pay for out-of-network cost sharing for the contract year.

Line 3 - Combined. Enter the maximum total dollar amount that a member could pay in the contract year for cost sharing both in- and out-of-network.

Line 4 - Maximum Cost Sharing Description. In the text box provided, briefly explain the methodology used to reflect the impact of maximum cost sharing on the PMPM values entered in Section III.

SECTION III – DEVELOPMENT OF CONTRACT YEAR COST SHARING PMPM (PLAN'S NON-ESRD RISK FACTOR)

Section III summarizes the cost sharing for all services included in the plan benefit package. The service categories are the same as presented in previous worksheets, except that line s (COB) has been omitted. Please note that for some service categories, (e.g., Inpatient Facility), there is more than one cost sharing line available. Multiple lines allow you to enter multiple cost sharing items in a service category to better match the PBP. In addition to the lines presented, the user may also use the ten blank lines at the bottom of the section to include additional cost sharing items that do not fit into an already defined service category line item. Do not insert any additional rows.

See Appendix B for information regarding supporting documentation for cost sharing utilization assumptions and plan level deductible.

The BPT allows for flexibility in entering cost sharing information. Below are some examples:

Example 1: The PBP contains in-network inpatient cost sharing of $100 per day for both Acute and Psychiatric stays with no maximum cost sharing. Assume that the total in-network inpatient utilization/1000 is 2,000 days, 1,900 of which are for acute and the remaining 100 are for psych. These figures could be reflected in the bid form in either of the following ways:

Option A:

	Column g	Column i	Column j
Line a1 – Acute	1,900	$100.00	$15.83
Line a2 – Mental Health	100	$100.00	$ 0.83
Total	2,000	$100.00	$16.67

Option B:

	Column g	Column i	Column j
Line a1 – Acute	2,000	$100.00	$16.67
Total	2,000	$100.00	$16.67

Example 2: The PBP has in-network professional copays of $10 for PCP, $20 for specialists excluding mental health (MH) services, $20 copay for MH group sessions, and $40 copay for individual MH sessions. There is no in-network maximum cost sharing. Assume in-network office visit utilization is distributed as follows:

- PCP 5,000
- MH – Indiv. 50
- MH – Group 50
- Other Spec 2,900
- Total 8,000

Following are some of the options that could be used to complete the bid form:

Option A: Use finest level of detail, with individual mental health in line i3 and group mental health in line i6.

	col g	col i	col j
Line i1 – PCP	5,000	$ 10.00	$ 4.17
Line i2 – Specialist excl MH	2,900	$ 20.00	$ 4.83
Line i3 – Mental Health	50	$ 40.00	$ .17
Line i6 – Other	50	$ 20.00	$ .08
Total	8,000	$ 13.88	$ 9.25

Note that one of the blank rows at the bottom of the form could also be used to enter one of the mental health copays.

Option B: Same as Option A, but combine the individual and group mental health copays onto line i3.

	col g	col h	col i	col j
Line i1 – PCP	5,000	$10 per visit	$ 10.00	$ 4.17
Line i2 – Specialist excl MH	2,900	$20 per visit	$ 20.00	$ 4.83
Line i3 – Mental Health	100	$20/visit for group MH sessions, $40/visit for individual MH	$ 30.00	$ .25
Total	8,000		$ 13.88	$ 9.25

Option C: Enter all services on one line (e.g., i6).

	col g	col h	col i	col j
Line i6	8,000	$10/visit PCP $20/visit non-MH specialist $20/visit for group MH $40/visit for individual MH	$ 13.88	$ 9.25
Total	8,000		$ 13.88	$ 9.25

Column c – Service Category. This column is pre-populated for most of the available rows. When the blank rows at the bottom of the worksheet are used to provide detailed cost sharing information, the valid entries are as follows:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery

- OP Facility – Other
- Professional
- Part B Rx
- Other Medicare Part B
- Transportation (Non-Covered)
- Dental (Non-Covered)
- Vision (Non-Covered)
- Hearing (Non-Covered)
- POS
- Health & Education (Non-Covered)
- Other Non-Covered

Column d – Service Category Description. This column provides a description for many of the fixed line cost sharing items. For lines with multiple options (e.g., Inpatient Facility), the description is provided to help you provide detailed information that can easily be checked against the PBP. You may input a description if using a blank row at the bottom of the worksheet to enter additional cost sharing lines.

Column e – Measurement Unit Code. For each cost sharing line, enter the appropriate measurement unit from the list below. The valid utilization types vary by service category, consistent with previous worksheets.

- A - Admits
- D - Days
- BP - Benefit Period
- V - Visits
- P - Procedures
- T - Trips
- S - Scripts
- O - Other
- Coin - Coinsurance
- Ded - Deductible (only used for single line items, such as per benefit period deductibles; deductibles that apply to multiple service categories are entered in the footnote and column f)

Column f – Effective In-Network Plan-Level Deductible PMPM. If there is an in-network plan-level deductible, you must enter the effective amount of the deductible on each service category line affected. For each service that is subject to the plan-level deductible, enter an amount such that the sum total represents the effective PMPM value of the deductible. Enter the actual in-network plan-level deductible amount (e.g., $500) in the footnote.

Column g – In-Network Util/1000 or PMPM (after plan-level deductible has been satisfied, and includes the impact of the OOP maximum). Enter the projected in-network utilization/1000, or PMPM value in the case of coinsurance, after the plan-level deductible has been satisfied and including the impact of the OOP maximum.

Enter the PMPM pricing impact of the in-network OOP maximum in the second footnote. (This value should reflect the PMPM difference in pricing for cost sharing before the OOP max and after the OOP max has been applied.)

Column h – In-Network Cost Sharing Description. Enter a description of the in-network cost sharing for each service category. Include any notes such as "for 1st 5 days". This is a text field.

This BPT field must contain descriptions of *all* plan cost sharing included in the PBP. This includes descriptions of *all* PBP benefits priced within each BPT service category. Since each BPT category may map to several PBP benefit categories, this field must provide details on all benefits priced together within each BPT service category.

All descriptions entered must be easily matched back to the PBP.

This field should be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits in the PBP are consistent with the benefits priced in the BPT, as part of the quality control for your bid submission. We recommend that the actuary include the PBP service categories (descriptions and possibly the PBP line #s) that are priced in each row of Worksheet 3.

Plans are required to use this field to describe all in-network benefits priced in the BPT. Even if there is no cost sharing for a particular service category, you must enter a comment indicating the zero cost sharing arrangement (i.e., $0.00 copay or 0% coinsurance). This column must not be left blank.

Column i – In-Network Effective Copay/Coinsurance (after the plan-level deductible has been satisfied, and includes the impact of the OOP maximum). Enter the projected effective in-network cost sharing amount after the plan-level deductible has been satisfied and including the impact of the OOP max. This amount should represent either the effective copay (if utilization is entered in column g) or the effective coinsurance percentage (if PMPM is entered in column g).

Column j – In-Network PMPM. These cells are calculated and reflect the projected cost sharing value PMPM for in-network services, excluding the effective in-network plan-level deductible. The formula uses the utilization or PMPM amounts in column g and the effective copay or coinsurance in column i.

- If the measurement unit is coinsurance ("Coin"), then the calculation is column g times column i.
- For measurement units other than coinsurance, the calculation is column g times column i divided by 12,000.

Column k – Total In-Network Cost Sharing PMPM. These cells are calculated as the sum of columns f and j. This column is the total projected cost sharing for in-network services.

Column l – Out-of-Network (OON) Cost Sharing Description. Enter a description for the out-of-network cost sharing of each service category. Include any notes such as "for 1st 5 days." This is a text field.

This BPT field must contain descriptions of *all* plan cost sharing included in the PBP. This includes descriptions of *all* PBP benefits priced within each BPT service category. Since each BPT category may map to several PBP benefit categories, this field must provide details on all benefits priced together in each BPT service category.

All descriptions entered must be easily matched back to the PBP.

This field should be used by plan managers, marketing staff, and plan actuaries to ensure that the benefits in the PBP are consistent with the benefits priced in the BPT, as part of the quality control for your bid submission. We recommend that the actuary include the PBP service categories (descriptions and possibly the PBP line #s) that are priced in each row of Worksheet 3.

Plans are required to use this field to describe all out-of-network benefits priced in the BPT. Even if there is no cost sharing for a particular service category, you must enter a comment indicating the zero cost sharing arrangement (i.e., $0.00 copay or 0% coinsurance). This field must not be left blank for plans that have out-of-network benefits.

Column m – Out-of-Network Cost Sharing PMPM. Enter the effective value of cost sharing for out-of-network benefits for each service category. This column must reflect the total projected cost sharing for all out-of-network services.

Enter the actual OON plan-level deductible in the footnote. Enter the pricing impact of the OON OOP maximum in the second footnote. (This value should reflect the PMPM difference in pricing for OON cost sharing before the OOP max and after the OOP max has been applied.)

Column n – Grand Total Cost Sharing PMPM (In-Network and Out-of-Network). This column is calculated as the sum of the in-network cost sharing (column k) and the out-of-network cost sharing (column m).

Worksheet 4 - MA Projected Revenue Requirement PMPM

This worksheet uses the information from previous worksheets for the allowed costs (Worksheet 2) and cost sharing (Worksheet 3) to determine net medical costs. Non-benefit expenses and gain/loss margins are entered to establish the plan's revenue requirements for the contract year. Values are allocated between Medicare-Covered Benefits and A/B Mandatory Supplemental Benefits and reflect the plan's non-ESRD risk factor for the contract period.

In Section IV, the plan must enter the projected "subsidy" for ESRD enrollees. ESRD enrollees must be excluded from all other sections of the BPT.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The allocation of allowed costs and cost sharing between Medicare-Covered and A/B Mandatory Supplemental benefits.
- The cost sharing test in Section III if the plan does not fall within the allowable limit.
- Non-benefit expense assumptions.
- Gain/loss margin.
- ESRD information provided.

SECTION I - GENERAL INFORMATION

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

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

Plan's non-ESRD Risk Factor (for the contract period) – The non-ESRD risk factor is obtained from Worksheet 5.

Lines a through r and line u.

Column e – Allowed PMPM for Total Benefits. The allowed PMPM is obtained from Worksheet 2 column O. No user inputs are necessary.

Column f – Cost Sharing for Total Benefits. The total in- and out-of-network cost sharing PMPMs are obtained from Worksheet 3 column N (except for COB in line u). No user inputs are necessary.

Column g – Net PMPM for Total Benefits. The Net PMPM is calculated as column e less column f.

Columns h and i - Percentage for Covered Services. The PMPM amounts shown in columns e through g reflect *all* benefits covered by the MA plan. In columns h and i, you must enter the expected percentages of these benefits that represent

Medicare-Covered benefits. The percentages in column h are used to allocate allowed costs (column e) between Medicare-Covered (column l) and A/B Mandatory Supplemental Benefits. The percentages in column i are used to allocate the plan's cost sharing (column f) between Plan Cost Sharing for Medicare-Covered services (column k) and cost sharing for A/B Mandatory Supplemental Benefits.

For services that are Non-Covered as defined, the percentage is defaulted 0.0% (e.g. line l, Transportation Non-Covered). For all other services, the plan must estimate the percentage of Covered Services for both the allowed costs and the cost sharing. The user must enter these percentages in columns h and i.

Example: The plan estimates that the Allowed PMPM in column e for Outpatient Facility Emergency services represents that 99.9% of those costs are for Medicare-Covered services and 0.1% of those costs are for A/B Mandatory Supplemental Benefits, whereas the cost sharing PMPM in column f represents that 98.0% of the cost sharing is for Medicare-Covered services and 2.0% of the cost sharing is for A/B Mandatory Supplemental Benefits. The entries in columns h and i would be as follows:

(c)	(h)	(i)
	% **for**	**Cov. Svcs.**
Service Category	Allowed	Cost Sharing
f. OP Facility – Emergency	99.9%	98.0%

For "Part B Only" plans, the Medicare-Covered percentage for inpatient services (lines a and b) should equal 0.0%. Also, Home Health services (line c) should be approximately 50%, which represents the national average portion of Medicare-Covered Home Health provided under Part A.

See Appendix B for information regarding supporting documentation for the allocation of costs and cost sharing between Medicare-Covered and Mandatory Supplemental.

Column j – Fee-for-Service Medicare Actuarial Equivalent (AE) Cost Sharing Proportions. These values are populated based on the enrollment projections entered in Worksheet 5.

Column k – Plan Cost Sharing for Medicare-Covered Services. This column calculates the portion of the plan's cost sharing that is attributable to Medicare-Covered benefits (calculated as column f times column i). This column is used to determine the Reduction of A/B Cost Sharing in column p.

Columns l through n – Medicare-Covered using Actuarial Equivalent Cost Sharing. These columns are calculated automatically and are the basis for the costs included in the Plan A/B Bid.

Column l – Medicare-Covered Allowed PMPM. The Medicare-Covered Allowed costs are calculated based on the percentage of Medicare-Covered benefits input by the plan in column h. Column l is calculated as column e times column h.

Column m – Fee-for-Service Medicare Actuarial Equivalent Cost Sharing. The FFS Medicare AE cost sharing PMPMs are based on the proportions in column j. Column m is calculated as column j times column l.

Column n – Net PMPM. Calculated as column l minus column m.

Columns o through q – A/B Mandatory Supplemental (MS) Benefits. These columns are calculated automatically and are the basis for the costs included in the A/B Mandatory Supplemental Premium.

Column o – Net PMPM for Additional Services. These amounts reflect the net costs (i.e., allowed costs less enrollee cost sharing) for Non-Covered benefits. This column is calculated as the allowed costs for Non-Covered benefits (column e minus column l) less the cost sharing for Non-Covered benefits (column f minus column k).

Column p – Reduction of A/B Cost Sharing. This column is the difference between FFS actuarial equivalent cost sharing and the plan cost sharing for Medicare-Covered services, calculated as column m minus column k. This is sometimes referred to as the "FFS cost sharing buydown."

Column q – Total A/B Mandatory Supplemental Benefits. This column is calculated as the sum of columns o and p.

Line s – ESRD. This line is populated based on Section IV.

Line t – Additional Benefits (employer bids only). This line is populated based on Section V.

Line v – Total Medical Expenses. The total medical expense is the sum of lines a through u, except for column j. The value in column n is the net medical cost included in the Plan A/B Bid. The value in column q is the net medical cost included in the A/B Mandatory Supplemental (MS) Premium.

Line w – Non-Benefit Expenses. The user must enter the non-benefit expense information for total MA benefits in column g for the four categories described below. (Note: In the CY2007 bid instructions, "non-benefit expenses" were referred to as "non-medical expenses".)

The worksheet distributes the non-benefit expenses proportionately between Medicare-Covered (column n) and A/B Mandatory Supplemental (column q) for each category. Non-benefit exp enses are also distributed within A/B Mandatory Supplemental benefits between Additional Services (column o) and Reduction of A/B Cost Sharing (column p). The proportions are described in these instructions and exclude the PMPM impact of the ESRD subsidy.

The non-benefit expenses must be shown separately for the following categories:

- Marketing & Sales.
- Direct Administration (i.e., functions that are directly related to the administration of the Medicare Advantage program, such as customer service, billing and enrollment,

medical management, claims administration, etc.). Medicare User Fees and Uncollected Enrollee Premium must also be included in Direct Administration.

- Indirect Administration (i.e., functions that may be considered "corporate services," such as CEO, accounting operations, actuarial services, legal services, human resources, etc.).
- Net Cost of Private Reinsurance (i.e., reinsurance premium less projected reinsurance recoveries).

All non-benefit expenses must be reported using the appropriate generally accepted accounting practice (GAAP) methodology (to the extent this is consistent with the MAOs standard accounting practices, if the MAO is not subject to GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to relevant GAAP principles. Guidance on GAAP standards are 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.

We expect costs common to offering a Medicare-Advantage-Prescription-Drug (MA-PD) plan to be allocated proportionately between the Medicare Advantage and Part D pricing tools.

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

- Expenditures for tangible assets must be capitalized and amortized according to relevant GAAP principles, e.g., a new computer system purchased by a non-profit MAO in 2006.
- Expenditures for non-tangible assets, e.g., salaries and benefits, must be reported consistent with the MAOs internal accounting practices and the reporting of similar expenditures in other lines of business.

Additionally, for organizations that have entered into administrative service agreements, the non-benefit expense must reflect the actual cost of providing services, which may be different from the contractual charge.

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

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a zero ($0.00) in the cell.

CMS may request supporting documentation for non-benefit expenses during the bid review process. Such documentation could include further analysis of non-benefit expense categories (separating claim adjudication, network management, customer service, etc). In addition, distinctions between start-up versus ongoing costs and fixed versus marginal costs may be examined.

Lines w1 through w4 - Non-Benefit Expense. Total non-benefit expenses are input in column g and allocated proportionately between Medicare-Covered (column

n) and A/B Mandatory Supplemental (column q). Note that the same proportion is used for each line item. The allocation is based on the relative proportion of the plan's revenue requirements for Medicare-Covered ("bid") and A/B Mandatory Supplemental, excluding the PMPM impact of the ESRD subsidy.

Column g – **Non-Benefit Expense PMPM for Total Benefits**. Enter the PMPM by category.

Column n – **Non-Benefit Expense PMPM for Medicare-Covered**. These values are calculated as column g minus column q.

Column q – **Non-Benefit Expense PMPM for A/B Mandatory Supplemental**. These values are calculated based on the relative proportion of revenue requirements for A/B Mandatory Supplemental, excluding the impact of the ESRD subsidy.

Line w5, columns g, n, and q - Total Non-Benefit Expense. The sum of lines w1 through w4.

Line w5, columns o and p - Total Non-Benefit Expense for Additional Services and Reduction of A/B Cost Sharing. The total non-benefit expense for A/B MS benefits (column q) is allocated between Additional Services (column o) and Reduction of A/B Cost Sharing (column p). The allocation is based on the relative proportions of the revenue requirements for Additional Services and Reduction of A/B Cost Sharing, excluding the impact of the ESRD subsidy.

Line x – Gain/Loss Margin. The user must input the projected PMPM for the gain or loss in column g for total MA services. Gain/loss margin refers to the additional revenue requirements above and beyond the requirements needed to cover medical expenses and non-benefit expenses.

The gain/loss margin is distributed proportionately between Medicare-Covered and A/B Mandatory Supplemental. The allocation is based on the relative proportions of the revenue requirements for Medicare-Covered and A/B Mandatory Supplemental, excluding the PMPM impact of the ESRD subsidy.

As with the medical expenses and administrative costs, the gain/loss margin must reflect the revenue requirements of benefits provided under the plan. Accordingly, the gain/loss margin is to be based on an accepted actuarial technique, such as Return on Investment (ROI) or Return on Equity (ROE).

One component of the bid's review by CMS will be assessment of the reasonableness of the gain/loss margin relative to other MA bids. Organizations will be required to provide justification of the margin for bids with relatively large projected gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other supporting documentation. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

Do not leave a field blank to indicate a zero amount. If zero is the intended value, enter a zero ($0.00) in the cell.

CMS may request supporting documentation for gain/loss margin during the bid review process. This documentation could include further analysis of the organization's return on equity and distinctions between recouping start-up costs versus ongoing organizational gain/loss.

The following Q&A guidance regarding profit was released by CMS on May 16, 2005 via HPMS:

> Question: What is CMS' policy with respect to the development, and CMS' review, of the profit margin assumptions in bids submitted by Medicare Advantage Organizations and Part D Plans?
>
> Answer: CMS will review the reasonableness of various components of plan bids, including the profit component. CMS will use a statistical approach to assess whether a given plan's profit margin is fairly representative of the range of values expected by most plans. Medicare Advantage Organizations and Part D Plans that submit plan bids with profit margins outside of this range will be asked to further justify their values, and the results will be considered accordingly.
>
> CMS would allow varied gain/loss margins for separate bids offered by an organization, under certain circumstances. The margin variability must be based on bid-specific factors such as risk margins, surplus requirements, taxes, and other key factors used in the development of the organization's aggregate gain/loss requirement.
>
> CMS would allow negative profit margins in certain circumstances, such as for new market entrants. However, we would not normally allow a plan to have negative profit margins over an extended period of time or without a business strategy that projects positive margins in future years.

Line y – Total Revenue Requirement. The sum of lines v (medical expense), w5 (non-benefit expense), and x (gain/loss margin). The value in column n is the total revenue requirement of the Plan A/B Bid.

Line z – Percent of Revenue Ratios (excluding ESRD). These lines calculate the ratio of net medical expense, non-benefit expense, and gain/loss margin as a percentage of revenue. These ratios exclude the PMPM impact of the ESRD subsidy.

SECTION III – COMPARISON OF COST SHARING FOR COVERED SERVICES WITH FFS MEDICARE

This section computes whether the plan's cost sharing PMPM is within the allowable limit (i.e., does not exceed original Medicare cost sharing). No user inputs are required.

Line 1. Standardized FFS Cost Sharing for Medicare-Covered Services. This value is populated based on the enrollment projections entered in Worksheet 5. No user input is required.

Line 2. Standardized Plan Cost Sharing for Covered Services. Plan cost sharing PMPM from line v of column k, standardized to a 1.000 beneficiary. No user input is required.

The plan cost sharing includes both in-network and out-of-network. For Regional PPOs, per section 1852(a)(1)(B)(ii) of the Social Security Act, only in-network services provided by an RPPO are subject to this test. Thus, line 3 may display a "No" for an RPPO bid, and the plan's cost sharing requirements may still meet the statutory requirements. The supporting documentation submitted by the plan must support that the in-network cost sharing is within the allowable limit.

Line 3. Is Covered Cost Share Within FFS Medicare Limit? No user input is required. Displays either "Yes" or "No" based on lines 1 and 2.

If the plan's cost sharing (in line 2) is greater than the allowable limit (in line 1), a "No" is displayed and supporting documentation is required (see Appendix B).

SECTION IV – DEVELOPMENT OF PROJECTED CONTRACT YEAR ESRD "SUBSIDY"

The benchmarks calculated in the CY2008 MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan, including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In an effort to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, Section IV allows for an adjustment. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits.

All plans *must* enter the projected CY ESRD member months. Do not leave this field blank. If the plan is expecting zero ESRD enrollees during the contract period, then enter a zero (0) in this field.

Bids that are based on a credible block of ESRD experience are expected to complete the ESRD fields for Basic, or Medicare-Covered, benefits. (Obviously, due to the higher expected level of per-enrollee expenditures, the credibility thresholds for individuals in ESRD status will typically be lower than those based on non-ESRD populations.) Organizations that complete this section are required to submit supporting documentation for this adjustment, including base period (e.g., 2006) revenues and medical expenditures for Medicare-Covered benefits provided to enrollees in ESRD status, relevant base-to-contract year trend factors, and a short narrative on the credibility approach applied to the ESRD experience.

The applicable fields to be completed in the Medicare-Covered section are (i) projected CMS capitation revenue, (ii) projected medical expenses, and (iii) projected non-benefit expenses. The projected margin requirement is calculated based on the values for the non-ESRD bid. All fields in this section are to reflect Medicare levels of cost sharing (e.g., 20 percent cost sharing for Part B services once the deductible has been met) and must be reported on a "per ESRD member per month" basis.

The form will calculate the plan's costs for basic benefits of ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD enrollees).

The Mandatory Supplemental part of Section IV *must* be completed for all bids that reflect credible Medicare-Covered experience for enrollees in ESRD status. Bids that do not have

credible Medicare-Covered experience are encouraged to reflect this incremental cost for supplemental A/B benefits. The inputs in this section are (i) the projected cost sharing reduction PMPM for ESRD enrollees, and (ii) the projected PMPM cost of additional benefits for ESRD enrollees. Entries must be reported on a "per ESRD member per month" basis.

The form will calculate the incremental cost of Supplemental Benefits for ESRD enrollees and will allocate these costs across all plan members (ESRD and non-ESRD).

The ESRD subsidy calculated in this section is used in line s of Section II.

SECTION V – FOR EMPLOYER/UNION-ONLY GROUP WAIVER PLAN (EGWP) BIDS ONLY ("800-SERIES" BIDS)

This section may be used by employer/union-only group waiver plan (EGWP) bids ("800-series" plan IDs) to provide CMS with the costs associated with additional "unspecified" benefits. This includes Employer/Union Direct Contract Private Fee-for-Service plans (i.e., plan type equal to "ED PFFS").

These services may be funded by rebate dollars. Consistent with individual-market bids, all rebates available to the plan must be allocated on Worksheet 6.

See Appendix D for further information on group bids.

Line 1. PMPM for Additional (Unspecified) Mandatory Supplemental Benefits. Users may enter the PMPM value of *medical costs* associated with additional "unspecified" benefits. The benefits represented by this value do not need to appear in the filed Plan Benefit Package, and may be customized for each employer or union group that enrolls in the plan. See Appendix D for further guidance on the use of this field.

This value will be used in line t of Section II. Note that the non-benefit expenses and gain/loss margin will be proportionately allocated.

Worksheet 5 - MA Benchmark PMPM

This worksheet calculates the A/B benchmark and evaluates whether the plan realizes a savings or needs to charge a basic member premium.

All information provided on Worksheet 5 must exclude ESRD enrollees.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- The development of plan-provided ISAR factors, if used (Regional PPO plans only).
- The development of projected risk factors.

Below is a brief description of the sections contained in this worksheet:

- Section II – Summarizes the development of the benchmarks and bids.
- Section III – Summarizes the development of the Savings or Basic Member Premium.
- Section IV – Development of Regional A/B Benchmark (including the Statutory Component of Regional Benchmark).
- Section V - Projected plan-specific information for counties within the service area.
- Section VI – Other Medicare Information (populated based on the enrollment projection).

The A/B Benchmark calculation is based on the following data elements:

- Service Area: Counties within the MA service area defined by their respective Social Security Administration (SSA) State-County codes.
- Projected Member Months (excluding ESRD): Projected non-ESRD member months, reported by county.
- Projected Risk Factor (excluding ESRD): Projected average risk factor for non-ESRD enrollees.
- Medicare Secondary Payer Adjustment Factor: Factor relative to all payments.
- For RPPOs, the mix of Medicare beneficiaries (nationally) between original Medicare and Medicare Advantage (used to weight the statutory and plan bid components of the regional A/B benchmark).

SECTION I - GENERAL INFORMATION

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

SECTION II – BENCHMARK AND BID DEVELOPMENT

Line 1 – Standardized A/B Benchmark (at 1.000 risk score). This value is obtained from Section IV for regional plans and from Section V for local plans.

Line 2 – Medicare Secondary Payer (MSP) Adjustment. User input is required. Do not leave this field blank. If zero percent is the projected value, enter a zero (0) in this field.

This entry can be calculated, using the Medicare Membership Report (MMR) data, as the ratio of total working aged adjustment dollars divided by total payments before reduction for user fees or working aged.

Line 3 – Weighted Average Risk Factor (excl ESRD). This value is obtained from Section V.

Line 4 – Conversion Factor. Calculated as (1.000 minus line 2) x line 3.

Line 5 – Plan (or Regional) A/B Benchmark. Calculated as line 1 x line 4.

Line 6 – Plan A/B Bid. This value is obtained from Worksheet 4.

Line 7 – Standardized A/B Bid (@ 1.000). Calculation is line 6 divided by line 4.

SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

Line 1 – Savings. The difference between the Plan (or Regional) A/B Benchmark and the Plan A/B Bid, but not less than zero.

Line 2 – Rebate. Calculated as 75% of the Savings (in line 1).

Line 3 – Basic Member Premium. The Standardized A/B Bid less the Standardized A/B Benchmark, but not less than zero.

SECTION IV – STANDARDIZED A/B BENCHMARK – REGIONAL PLANS ONLY

This section calculates the Standardized A/B Benchmark for Regional PPO plans.

Line 1 – Statutory Component. The PMPM amount, defined by region, is pre-populated by CMS. The weighting is also pre-determined by CMS and populated in the bid form.

Line 2 – Plan Bid Component. The plan bid component will be announced by CMS after the regional bids are submitted. It will likely be announced at the same time that the Part D National Average is announced (generally in August).

Plans may input an *estimated* average regional bid amount in their initial bid submission in June.

For bids that are submitted prior to the announcement of the RPPO averages, there are two options for completing this field: (i) leave the cell blank, in which case the submitted plan's standardized bid (Section II, line 7) is used as the Plan Bid Component, or (ii) input a reasonable estimate of the average RPPO bid for the region.

The RPPO announcement includes the weighted average MA RPPO bid for each region. Organizations will be instructed to submit revised RPPO MA BPTs (generally in August) with the applicable average bid amount entered in Line 2. Employer bids ("800-series" bids) are also required to resubmit at that time to reflect the RPPO average bids in Line 2. Any changes in rebates due to the actual plan bid component must be re-allocated at that time.

Line 3 – Standardized A/B Benchmark – Regional Plans. This line is calculated as the weighted average of lines 1 and 2 (if line 2 has a value entered). If line 2 does not have a value entered (i.e., for a pre-announcement bid submission for which the plan has not entered an estimate value), the amount from Section II, line 7 is used in the calculation.

SECTION V – COUNTY LEVEL DETAIL AND SERVICE AREA SUMMARY (EXCLUDING ESRD)

This section contains detailed data by county and develops plan-specific county-level MA payment rates. For most plans, the only user inputs are the State-County code (column b), projected member months (column e), and projected risk factors (column f). Entries must reflect plan-specific enrollment projections for each county within the service area.

In the event that the variation in the MA rates is not an accurate reflection of the variation in a plan's projected costs in its service area, CMS will consider allowing MA organizations, on a case-by-case basis, to request that payment rates for RPPOs be developed using plan-provided geographic intra-service area rate (ISAR) factors. MA organizations that wish to propose plan-provided ISAR factors for regional plans must input such amounts in this section, as described below.

Line 1 – Use of Plan-Provided ISAR Factors. Regional plans that wish to use ISAR factors to develop their county payment rates must enter "Yes". (Technical note: Do not enter "Y" in this field – enter the entire word "Yes")

Line 2 – Total or Weighted Average for the Service Area. The county-level data are summarized in this line, weighted by projected member months.

Line 3 – County-Level Detail.

Column b – State-County Code. Enter the Social Security Administration (SSA) State-County codes that define the MA service area, in accordance with the following:

- Each State-County code must be entered as a text input (i.e. must include a preceding apostrophe) and include all leading zeroes (e.g., '01000). This field has been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (i.e., using a preceding apostrophe) including any leading zeros.
- If the service area has more than one county, do not leave any blank rows between the first and last State-County code entered.

- Do not enter the same State-County code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area (OOA) county, "99999". OOA enrollees are not represented in the benchmark calculation.
- The county codes entered in the BPT must match the service area defined in HPMS by the MA organization.

Technical note: In the "finalized" BPT file, the county level section will be sorted in a descending order, based on the county codes entered in column b. See the technical instructions (Appendix H) for further information.

Column c – State. The worksheet will display the applicable State name based on the corresponding code entered in column b. No user entry is required.

Column d – County Name. The worksheet will display the applicable county name based on the corresponding code entered in column b. No user entry is required.

Column e – Projected Member Months (excluding ESRD). Enter the projected contract year member months for each county in the service area. The projected member months must include both aged and disabled members, but exclude ESRD members. The projected member months should be developed using data on members enrolled in the plan as of early 2007.

Column f – Non-ERSD Projected Risk Factor. Enter the risk factors for the projected non-ESRD membership by county. In accordance with Appendix B, supporting documentation for the development of the projected risk scores is required.

Risk Score Development for CY2008

The goal of the risk score development is to develop a plan average risk score for the projected CY2008 population. CMS re-estimated the CMS-HCC risk model on which risk scores were determined for CY2007; we refer to this re-estimated model as the "recalibrated" or "new" model. Because the CMS-HCC model has been recalibrated, the appropriate starting point to develop a projected CY2008 risk score is a score calculated under the new CMS-HCC model.

FFS normalization, a process which adjusts risk scores to a 1.000 average for each payment year, must be applied to risk scores calculated under the new model. FFS normalization of the risk scores will take place prior to payment. The normalization factor to be applied (that is, risk scores will be divided by this factor) will be announced in the Advance Notice of Methodological Changes for Calendar Year 2008 for Medicare Advantage (MA) Payment Rates. [In CY2006, under the original CMS-HCC model, FFS normalization was incorporated into the benchmarks; thus no adjustment was made in the development of the risk scores.]

Risk Score Development for New Plans

Acceptable approaches for the development of risk scores depends on whether or not the plan is new or exists currently. New plans (i.e. those plans not expected to enroll

existing MA enrollees) should estimate risk scores based on the expected medical expenses for their projected enrollees. Further, the risk scores for new plans must be developed based on the new CMS-HCC model, which can be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/, under "risk adjustment".

Risk Score Development for Existing Plans
The preferred method for development of projected risk scores for existing plans is:

1. Use a plan average risk score computed under the new CMS-HCC model as the basis for risk score development. Organizations must calculate risk scores for their enrollees using the 2008 CMS-HCC risk adjustment software available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. Organizations that calculate risk scores using the new model software must appropriately assign beneficiaries to the correct version of the model (community, institutional, or new enrollee). New enrollees are defined as beneficiaries with less than 12 months of Medicare Part B enrollment in the data collection period. Organizations should make appropriate adjustments to account for incomplete diagnosis data for full-risk enrollees for whom they do not have 12 complete months of diagnostic data in the data collection period (i.e. those beneficiaries newly enrolled to the plan from FFS or from another MA organization) otherwise their average risk score will be underestimated for the projected population.

2. Adjust the new CMS-HCC risk scores as follows:
    a. Adjust for seasonality. CMS has consistently found that average plan risk scores decline throughout the payment year. Our research indicates the risk scores decline on average about 0.57% per month due to changes in the insured population; however, your plan's experience may vary and you should adjust accordingly. Typically, a plan's risk score is average for the year in the month of July. Therefore, a reasonable adjustment is to multiply your May risk score by 0.9886.
    b. Adjust for the impact of submitting diagnoses data after April 1, 2007 (i.e. late data). MA and MA-PD plans have approximately 12 months after the end of the data collection year to submit additional diagnostic data which impact their final risk score. Our experience shows that the average effect of data submitted after March of the contract year is to increase risk scores by 2.5%. Again, each plan's experience will vary and you should adjust your projected risk score accordingly.
    c. Adjust for projected change in risk score from 2007 to 2008. Plan risk scores may be projected to change between 2007 and 2008 for a variety of reasons, notably changes in the characteristics of the projected enrolled plan population and/or improvements in diagnostic data collection and submission. Plans should use their historical experience to project risk scores to 2008.
    d. Divide the 2008 plan projected risk score by the 2008 FFS normalization factor. The 2008 FFS normalization factor is TBD. This step ensures that

the projected risk score used to calculate the bid and benchmark is adjusted in the same manner as payments will be adjusted in 2008.

Example of Risk Score Development for Hypothetical Plan

	Base Score/ Adjustment	Adjusted Score for use in 2008 Bid	Comments
New CMS-HCC Risk Score (Enrollment as of May 2007 MMR)	1.00	1.00	Hypothetical Plan Risk Score under new CMS-HCC model using calendar year 2006 diagnoses data w/ run out through 4/1/2007
Seasonality Adjustment	1.00 * (1 - .0057)^2	.9886	Base risk score adjusted to July 2007 to reflect average plan score for calendar year 2007
Late Data Adjustment	.9886*1.025	1.0133	Adjustment for late data submitted after 4/1/2007 and prior to 1/31/2008
2007-2008 plan risk score change projection	1.0133*1.03	1.0437	Hypothetical adjustment for projected changes in the health status of the plan's enrollment between 2007 and 2008
FFS Normalization of 2008 projected plan risk score	1.0437/1.029	1.0143	Application of FFS normalization factor to the projected 2008 risk score

Notes: Adjustments for seasonality and late data are based on CMS data modeling, 2007-2008 plan risk score change adjustment projection is purely hypothetical, FFS normalization adjustment will be applied to payment in 2008.

Thus, the resulting risk score to be input into Worksheet 5, Section V, column f, of the 2008 MA bid pricing tool is 1.0143. Please note, that the above example would typically apply to individuals enrolled in all counties in the plan's service area.

Column g – Plan-Provided ISAR Factors. CMS may allow MA organizations, on a case-by-case basis, to request that regional plan payment rates be developed using plan-provided geographic intra-service area rate (ISAR) factors in the event that the variation in the MA rates is not an accurate reflection of the variation in a regional plan's projected costs in its service area.

MA organizations that wish to propose plan-provided ISAR factors for regional plans must complete the following steps:

(i) Enter "Yes" in line 1, in response to the question: "Use of plan-provided ISAR?" (Technical note: Do not enter "Y" in this field – enter the entire word "Yes".)

(ii) Enter the plan-provided ISAR factors in column g of the county-level detailed table. Factors can be in the form of either PMPM values or a relative scale.

(iii) Provide support for the development of the plan-provided ISAR factors in accordance with Appendix B.

Column h – MA Risk Ratebook: Unadjusted. The worksheet will display the applicable published Ratebook risk rates for the contract period. If enrollee type is "A/B", the amounts shown are the total of Part A and Part B. If enrollee type is "Part B Only", the amount is the Part B rate only.

Column i – MA Risk Ratebook: Risk-Adjusted. The worksheet will calculate the risk-adjusted rates based on the rates in column h and the risk scores in column f.

Column j – ISAR scale. The worksheet will calculate the ISAR scale based on either the plan-provided ISAR factors in column g (if provided) or the Ratebook rates in column h.

Column k – ISAR-adjusted bid. The worksheet will calculate the ISAR-adjusted bid based on the ISAR scale in column j and the Standardized A/B Bid in Section II. Note that the payment rates represent coverage for Medicare Part A and Part B (except for Part-B only plans). The values will then be separated into Part A and Part B payment rates in columns l and m.

Columns l through m – Risk Payment rates. These columns are calculated based on the ISAR-adjusted bid in column k and the Risk Ratebook proportions for Part A and Part B.

SECTION VII – OTHER MEDICARE INFORMATION

This section contains county-level Medicare information used in the bid form. This section is populated based on the county codes input in column b and the projected member months entered in column e.

Columns n through p – Original Medicare Cost Sharing Proportional Factors. These columns are populated based on the enrollment projections and are used in column j of Worksheet 4.

Columns q through s – FFS Costs used to weight Original Medicare Cost Sharing. These columns are populated based on the enrollment projections and are used in the weighted averages (row 36) of columns n through p of Worksheet 5 Section VI.

Columns t through u – FFS Equivalent Cost Sharing. These columns are populated based on the enrollment projections and are used in Section III of Worksheet 4.

Columns v through w – Metropolitan Statistical Area (MSA). These columns are populated based on the enrollment projections. While not directly used in the BPT calculations, this information is helpful to CMS during bid reviews.

Worksheet 6 – MA Bid Summary

Worksheet 6 summarizes the results of the calculations of the bid form. In addition, some user inputs are required , as described below.

All information provided on Worksheet 6 must exclude ESRD enrollees.

SECTION I - GENERAL INFORMATION

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

SECTION II – OTHER INFORMATION

Section A – Part B Information

Line 1 – CMS Estimate of "Standard" Contract Year Part B Premium. This value is pre-populated by CMS.

Section 1839 of the Act, as amended by Section 811 of the 2003 MMA and Section 5111 of the 2005 Deficit Reduction Act, provides for an income-related reduction in the government subsidy of the Medicare Part B premium. Under this provision, for those beneficiaries meeting specified income thresholds, a monthly adjustment amount will be added to the standard Part B premium. We use the term "standard" to mean the premium amount excluding any income-based adjustments (as well as excluding other adjustments, such as late enrollment penalties).

Generally, effective 2007, the standard Part B premium amount becomes the lowest Part B premium a beneficiary would pay, with higher-income beneficiaries paying greater Part B premiums. (The only beneficiaries who pay less than the standard Part B premium are those whose Part B premium increase is limited by the increase in their Social Security check (the "hold harmless" provision) and those for whom the State or another third party pays for the Part B premium).

The addition of monthly adjustment amounts to the Part B premium obligation of higher-income beneficiaries will be phased-in over three years, beginning in 2007. Given the MA requirement that benefits must be uniform within an MA plan, the effect of this provision on MA plans is that the lowest Part B premium a plan can offer is the estimated standard amount net of rebates. (MA enrollees are required to pay the standard Part B premium, but it may be reduced by the MA organization through the use of rebate dollars.)

The amount pre-populated in the BPT is the estimated value of the standard Part B premium for the contract year at the time that the bid form is released.

See Section IIB for further information regarding allocating rebates to the standard Part B premium.

Line 2 – Part B % of USPCC. This value is pre-populated by CMS. For "Part B Only" bids, this percentage is used to estimate the Part A portion of the plan benchmark, which is used in line 3.

Line 3 – Maximum for Part A Package on Part B Only Members. Lines a through c do not require any user inputs. These lines use bid information to calculate the maximum that can be charged to Part B Only members for Part A services. On line d, enter the amount for Part B Only members for Part A services. The amount entered in line d cannot be greater than the maximum value shown to the right. If the bid's Enrollee Type is "A/B", then this field should be left blank.

Note: the MA premium actually charged to plan enrollees is calculated in Section IIIC, line 6.

Section B – Rebate Allocation for CY Standard Part B Premium

Line 1 – PMPM Rebate Allocation for Standard CY Part B Premium. Enter the PMPM amount of rebates that the plan wishes to use to reduce the standard Part B premium.

Line 2 – Rounded Part B Rebate Allocation. The PMPM amount entered in line 1 is rounded to one decimal (i.e., the nearest dime) to comply with withhold system requirements.

Line 3 – Does the plan intend to reduce the entire CY standard Part B premium using rebates? CMS is considering allowing plans the ability to fully reduce the standard Part B premium. The bid pricing tool and instructions are released annually in April, but the standard Part B premium is not released by CMS for the upcoming contract year until several months later. Therefore, plans must use the CMS pre-populated Part B premium *estimate* in the bid form (Section IIA line 1) to determine the level of rebates to allocate.

If a plan: (i) has allocated Part B rebates (in Section IIB, line 2) equal to the estimated CY standard Part B premium pre-populated at the time that the bid form is released (in Section IIA line 1), and (ii) intends to fully reduce the standard CY Part B premium (i.e., reduce to $0.00), enter "Yes" in this line. (Technical note: Do not enter "Y" in this field – enter the entire word "Yes".)

CMS will release further guidance directly to those plans that meet these criteria (i.e., have allocated rebates equal to the CMS pre-populated estimate and have entered "Yes" in this line), *if* it is determined by CMS that the full reduction is feasible for CY2008.

SECTION III – PLAN A/B BID SUMMARY

Section III summarizes the bid pricing tool information in three sections. Section A is an overview of the Plan A/B Bid and the costs of A/B Mandatory Supplemental benefits. Section A also contains some benchmark and risk score information from Worksheet 5. Section B contains the MA Rebate Allocation. Section C develops the estimated plan premium. Consistent with previous worksheets, note that any optional supplemental benefits/premiums are excluded.

Section A – Overview

This section summarizes information entered on previous worksheets.

Line 1 – Allowed Medical Cost. The allowed PMPM at the plan's contract year non-ESRD risk factor. These amounts are obtained from Worksheet 4.

Line 2 – Less Cost Sharing. Values are obtained from Worksheet 4.

Line 3 – Net Medical Cost. The sum of lines 1 and 2.

Line 4 – Non-Benefit Expenses. These amounts are obtained from Worksheet 4.

Line 5 – Gain/Loss Margin. These amounts reflect the estimated net gain/loss for the plan, including the amount of risk margin desired. These amounts are obtained from Worksheet 4.

Line 6 – Total Revenue Requirement. The sum of lines 3 through 5. These amounts are the required revenue at the plan's non-ESRD risk factor and are calculated prior to any rebate allocation.

Line 7 – Standardized A/B Benchmark. This amount is obtained from Worksheet 5.

Line 8 – Plan A/B Benchmark (or Regional A/B Benchmark for RPPO plans). This amount is obtained from Worksheet 5.

Line 9 – Non-ESRD Risk Factor. This amount is obtained from Worksheet 5.

Line 10 – Conversion Factor. This amount is obtained from Worksheet 5.

Section B – MA Rebate Allocation

This section indicates how the rebates are applied to the various options:

- Reduce A/B Cost Sharing.
- Other A/B Mandatory Supplemental Benefits.
- Standard Part B Premium buydown.
- Part D Basic Premium buydown.
- Part D Supplemental Premium buydown.

Plans may choose which category, or categories, in which to allocate rebates.

See Appendix F for information regarding the re-allocation of rebates (permitted for certain plans) after the publication of the Part D National Average Bid Amount by CMS.

Line 1 – MA Rebate Available. This amount is obtained from Worksheet 5.

Lines 2 through 6 – Rebate Allocations by Category. In the fourth column, enter the portion of the total MA rebate that is allocated to each of the A/B rebate options. Note that the rebate allocations for Part B and Part D premiums are entered in separate sections of this worksheet, to ensure that the rebate allocations are rounded consistently with withhold system requirements.

The first three columns distribute the allocated rebate among medical expenses, non-benefit expenses, and gain/loss in the same proportion as the A/B Mandatory Supplemental section of Worksheet 4. The fifth column contains the maximum value that may be entered for each rebate category.

The following rules apply for rebate allocations:

- The fifth column of this section shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum. Note that if the maximum value is negative (such as a negative Part D Basic premium before rebates), then the rebate allocation can be zero/blank.

- The total rebates allocated must equal the total rebates available. Plans are not permitted to under- or over-allocate rebates in total. This applies to all bids, including 800-series bids.

- No rebate allocations may be negative.

- Rebate allocations for "Reduce A/B Cost Sharing" and "Other A/B Mandatory Supplemental Benefits" must be rounded to two decimals.

- The rebate allocations for Standard Part B Premium, Part D Basic Premium, and Part D Supplemental Premium are rounded to one decimal (i.e., the nearest dime) due to withhold system requirements.

- Employer-only group bids (i.e., "800-series" plans) cannot allocate rebates to Part D.

- MA-only bids cannot allocate rebates to Part D.

- Rebates allocated to buy down the estimated standard Part B Premium are subject to the maximum amount shown on Worksheet 6. This maximum is the estimated CY2008 standard Part B premium at the time when the bid form is released by CMS. See the instructions for Section IIB for further information about rebates applied to the standard Part B premium.

Line 7 – Total Rebate Allocated. The sum of lines 2 through 6. This amount must equal the amount in line 1. If there are any "unallocated" rebates shown, including pennies, these amounts must be distributed among the categories available.

Section C – Development of Estimated Plan Premium

The MA Bid Pricing Tool calculates the plan's premium for services under the Medicare Advantage program. Estimated Part D premiums, calculated in the separate Part D BPT, are then entered in the MA BPT in order to:

- Underscore the relationship of MA rebates and Part D premiums.
- Recognize the integrated relationship of the MA and Part D programs, which is often viewed as a single product with a single premium.
- Display the total estimated plan premium (MA + PD).

When the bid is initially submitted in June, the Part D Basic premium entered in the MA BPT is an *estimated* value. The *actual* premium will be calculated by CMS when the Part D National Average Bid Amount is determined (generally in August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2008.

For local MA-only plans, the premium shown on the MA BPT in the initial submission in June is the final actual premium (*not* an estimate) since they are not affected by the Part D National Average or Regional PPO benchmark calculations. Local MA-only plans *do not* have an opportunity to resubmit in August for rebate reallocations. The initial bid submission in June must reflect the desired plan premium.

If a local MA-only plan wishes to offer a "whole-dollar" premium, the June bid submission must reflect a total premium that is rounded to the nearest dollar. The bid assumptions (such as gain/loss margin) must support the desired plan premium and the desired level of premium rounding. Local MA-only plans will not be given an opportunity to round the premiums after the initial June submission.

> Example: After initially completing the BPT for a local MA-only plan, the BPT produced a $0.00 Basic MA Premium (as Bid < Benchmark) and a $61.30 Mandatory Supplemental MA premium. The plan would like to offer a "whole-dollar" premium to their enrollees. Before submitting the BPT to CMS (via HPMS upload), the actuary would slightly revise the bid assumptions, such as gain/loss margin, to accomplish the rounded premium. For example, the actuary could reduce the gain/loss margin by 30 cents ($0.30) to achieve the $61.00 rounded premium. This should be completed before the BPT is submitted to CMS in early June.

MA-PD plans and regional MA-only plans do have an opportunity to reallocate rebates after the release of the Part D National Average Bid Amount and RPPO benchmarks. However, there are specific guidelines regarding what types of changes are permitted during the rebate reallocation period. Also, there are very specific rules regarding the *amount/level of rounding* permitted. Plans should not expect to make significant changes to the BPT in order to round premiums during the rebate reallocation period. Plans are also subject to the rules regarding the Part D target premium. See **Appendix F** for the premium and rounding rules that were released in the CY2007 Call Letter.

It is important to note that for **all** plans, the initial June bid submission must reflect the desired level of premium rounding, since there are specific rules regarding the level of premium rounding permitted thereafter.

MA-PD plans must identify, in the MA BPT Worksheet 6 Section IIIC line 10, their intention for the Part D target premium *in their initial June bid submission*. See instructions for line 10 of this section for further information on the Part D target premium.

Line 1 – A/B Mandatory Supplemental Revenue Requirements. This amount is obtained from Section IIIA.

Line 2 – Less Rebate Allocations. These amounts are obtained from Section IIIB, lines 2 and 3.

Line 3 – A/B Mandatory Supplemental Premium. The sum of lines 1 and 2.

Line 4 – Basic MA Premium. This amount is obtained from Worksheet 5.

Line 5 – Total MA Premium (excluding Optional Supplemental). The sum of lines 3 and 4.

Line 6 – Rounded MA Premium (excluding Optional Supplemental). The total MA premium from line 5 is rounded to one decimal (i.e., the nearest dime) to comply with withhold system requirements.

Line 7 – Part D Basic Premium. In line 7a, enter the Part D basic premium (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (i.e., the amount prior to application of any MA rebates).

In line 7b, enter the rebates that the plan wishes to allocate to the Part D Basic premium. The Part D rebate allocation should be rounded to one decimal. If it is not rounded to one decimal, then the bid form will round these rebates to one decimal (in line 7c), to comply with withhold system requirements.

Line 7d calculates the estimated Part D Basic Premium net of rebates. Line 7d equals line 7a minus line 7c.

The Part D Basic Premium in the MA BPT is an *estimate* when the bid is initially submitted in June. The actual plan premium will be calculated by CMS when the Part D National Average Bid Amount is determined (generally in August).

Line 8 – Part D Supplemental Premium. In line 8a, enter the Part D supplemental premium (found on the separate Part D bid form) after rounding. This amount must equal the amount on the Part D BPT (i.e., the amount prior to application of any MA rebates).

In line 8b, enter the rebates that the plan wishes to allocate to the Part D Supplemental premium. The Part D rebate allocation should be rounded to one decimal. If it is not rounded to one decimal, then the bid form will round these rebates to one decimal (in line 8c), to comply with withhold system requirements.

Line 8d calculates the Part D Supplemental Premium net of rebates. Line 8d equals line 8a minus line 8c.

Line 9 – Total Estimated Plan Premium. The sum of the rounded MA, Part D Basic, and Part D Supplemental premiums. This amount excludes any Optional Supplemental MA premiums.

Line 10 – Plan Intention for Part D Target Premium. When MA-PD bids are initially submitted in June, the Part D Basic premium in the bid forms is an *estimated* amount. The *actual* Part D Basic premium will not be known until CMS releases the Part D National Average Bid Amount. MA-PD plans can either "target" the estimated premium submitted in June or they can "target" the Low Income Premium Subsidy Amount (which is also not known until it is released later by CMS) as the Basic Part D premium amount.

For MA-PD plans, this line contains a drop-down menu with two options. MA-PD plans must choose one of the two options: "Premium amount displayed in line 7d" or "Low Income Premium Subsidy Amount". When CMS later releases the Part D National Average Bid Amount and LIS amounts, MA-PD plans will have an opportunity to reallocate rebates to return to this target premium amount. Based on the option selected in this field, the plan will be able to return to the target chosen when it was initially submitted in June.

The plan intention for the Part D target premium is chosen in the initial June bid submission. The plan cannot change the chosen target in a subsequent resubmission. CMS will consider only the option chosen in the June bid submission as the chosen target.

For MA-only plans, the target Part D premium is not applicable.

SECTION IV – CONTACT INFORMATION AND "DATE BID PREPARED" IDENTIFIER

In this section, enter the name, phone number, and email information for the plan contact, as well as for the certifying actuary. For the phone number, enter all 10 digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

The persons named in this section must be available for any actuarial questions and issues that arise during the review of the bid by CMS.

Section IV also contains a field labeled "Date Prepared." This field must contain the date that the BPT was prepared.

Worksheet 7 – Optional Supplemental Benefits

Worksheet 7 contains the actuarial pricing elements for any optional supplemental benefit packages to be offered during the contract year, up to a maximum of five optional supplemental packages.

For each of the five optional supplemental packages, the worksheet contains 20 category lines. If additional category lines are needed, provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. Do not insert any additional rows into the form.

MAOs may be required to provide supporting documentation for the items listed below (see Appendix B – Supporting Documentation):

- Non-benefit expenses and gain/loss margins that are inconsistent with the assumptions of the Basic Bid.

SECTION I - GENERAL INFORMATION

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

SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

Column b – **Package ID.** Enter an identification (ID) number to signify which package of optional supplemental benefits is being priced. The number 001 is used to identify the first package. Whole numbers in sequence (i.e., 002, 003) identify additional packages of optional supplemental benefits. Enter the package IDs that correspond to the packages enumerated and described in the PBP.

Column c – **Service Category.** Enter the service category. Valid entries are those consistent with the categories included on Worksheet 1:

- Inpatient Facility
- Skilled Nursing Facility
- Home Health
- Ambulance
- DME/Prosthetics/Supplies
- OP Facility – Emergency
- OP Facility – Surgery
- OP Facility – Other
- Professional
- Part B Rx

- Other Medicare Part B
- Transportation (Non-Covered)
- Dental (Non-Covered)
- Vision (Non-Covered)
- Hearing (Non-Covered)
- POS
- Health & Education (Non-Covered)
- Other Non-Covered

Column d – Benefit Category/Pricing Component. Enter a description of the benefit category/pricing component.

Column e – Allowed Medical Expense: Utilization Type. Enter the appropriate measurement unit from the list used for column f of Worksheet 1.

Column f – Allowed Medical Expense: Annual Utilization/1000. Enter the projected contract year annual utilization per thousand enrollees for allowed medical expenses for each benefit category.

Column g – Allowed Medical Expense: Average Cost. Enter the projected contract year average cost for allowed medical expenses for each benefit category.

Column h – **Allowed Medical Expense: PMPM**. Column h is calculated using the utilization reported in column f and the average cost information reported in column g.

Column i – Enrollee Cost Sharing: Measurement Unit Code. Enter the appropriate cost sharing measurement unit using the codes provided for column e of Worksheet 3.

Column j – Enrollee Cost Sharing: Utilization/1000 or PMPM. Enter the projected contract year utilization per thousand enrollees or the PMPM value in the case of coinsurance.

Column k – **Enrollee Cost Sharing: Average Cost Sharing.** Enter the projected contract year average per-service cost sharing amount or coinsurance percentage.

Column l – **Enrollee Cost Sharing: PMPM.** Column l is calculated using the utilization (or PMPM) reported in column j and the average cost (or coinsurance percentage) reported in column k.

Column m – **Net PMPM Value.** Column m is calculated as the Allowed PMPM (column h) minus the Cost Sharing PMPM (column l).

Column n – Non-Benefit Expense. Enter the total projected contract year non-benefit expense for each optional supplemental package offered. See Appendix B for information regarding supporting documentation for Optional Supplemental Packages' non-benefit expenses.

Column o – Gain/(Loss) Margin. Enter the total projected contract year gain/loss margin for each optional supplemental package offered. See Appendix B for information regarding supporting documentation for Optional Supplemental Packages' gain/loss margin.

Column p – Premium. The sum of columns m (medical expenses), n (non-benefit expenses), and o (gain/loss margin). The premiums are rounded to one decimal to comply with premium withhold system requirements.

Column q - Projected Member Months. Enter the total projected contract year member months for each optional supplemental package offered (not average members.

SECTION III - COMMENTS

Enter any comments needed to describe the optional benefit packages.

Two-Year Look-Back Form

The Two-Year Look-Back is a separate form that was developed to assist CMS in evaluating the accuracy of previously filed MA bids. The form provides OACT with data aggregated at the contract level, rather than at the bid level. It also provides a summary of costs separated by individual-market versus employer/union-only group market.

The form requires the user to input actual incurred revenue and expense information for the calendar year two years prior to the contract year being priced. For example, in contract year 2008, the experience year is 2006. CMS will compare the actual amounts entered in this form to the original projection (i.e., the 2006 MA BPT in contract year 2008).

The two-year look-back form must be completed at the contract-level (i.e., H#), not at the plan-level as BPTs are completed. This worksheet must be completed in "per member per month" values (PMPMs).

Contract Number. Displays the contract number.

Organization Name. Displays the organization name.

Contract Year. Displays the contract year.

Experience Year. Displays the experience year, which is two years prior to the contract year.

Line 1. Revenue. Columns f and g (Original Projection) must be completed using information from CMS. This information will be the weighted average of the 2006 MA BPT values, with the weights being the Medicare Membership Report (MMR) actual member months for each PBP included in the contract. Column h is the weighted average of columns f and g. The user must enter data into columns j and k (Actual Incurred). Column l is the weighted average of columns j and k. Columns n, o, and p calculate the ratio of actual-to-projected and do not require any user input.

The CMS-reported revenue is reduced for funds placed in the benefit stabilization fund and increased for monies withdrawn from the fund.

Line 2. Net Medical Expenses. Columns f and g must be completed using information from CMS. This information will be the weighted average of the 2006 MA BPT values. Column h is the weighted average of columns f and g. Columns j and k refer to data entered in footnote 2. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

The net medical expenses are to be reported on an experience (or incurred) basis, rather than GAAP (or accounting year) basis.

Line 3. Non-benefit Expenses. Columns f and g must be completed using information from CMS. This information will be the weighted average of the 2006 MA BPT values. Column h is the weighted average of columns f and g. The user must enter data in columns j and k. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

Line 4. Profit/(Loss) Before Taxes and Investment Income. All columns are automatically calculated as revenue (line 1e) less medical expenses (line 2d) and non-benefit expenses (line 3e).

Line 5. Key Statistics.

Line 5a - Member Months. Columns f and g must be completed using information from CMS, based on MMR data. The user must also enter data in columns j and k.

Line 5b - Non-ESRD Risk Factor. Columns f and g must be completed using information from CMS. The user must also enter data in columns j and k.

Lines 5c, 5d, and 5e. These fields are calculated automatically. No user input is required.

Footnote 2:
Incurred in Experience Year and Paid Through. The user must enter the "paid through" date.

Net Medical Expenses.

a. **Covered Benefits (excluding risk share)**. The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
b. **A/B Mandatory Supplemental Benefits**. The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
c. **Regional PPO Risk Share Paid/(Received)**. The user must enter data in the first two columns, and the total weighted average is calculated in the third column. The user must enter data in the next two columns for Claim Reserves, and a total weighted average is calculated.
d. **Total**. Calculates the sum of lines a through c.

Footnote 3:
Actual Incurred components of Net Reinsurance.

a. **Private Reinsurance Premium.** The user must enter data in the first two columns.
b. **Private Reinsurance Recoveries**. The user must enter data in the first two columns.
c. **Net Reinsurance Cost**. The sum of lines a and b.

Appendix A – Actuarial Certification

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

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

Actuarial Standards of Practice

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

- ASOP No. 5, Incurred Health and Disability Claims.
- ASOP No. 8, Regulatory Filings for Rates for Health Plan Entities. Particular focus is placed on the sections dealing with the Use of Business Plans to Project Future Results (3.2.3), Use of Past Experience to Project Future Results (3.2.4), Recognition of Benefit Plan Provisions (3.2.5) and Reasonableness of Assumptions (3.2.9).
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans.
- ASOP No. 23, Data Quality. Particular focus is placed on the following sections: Analysis of Issues and Recommended Practices (Section 3), Communications and Disclosures (Section 4).
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage.
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking. Particular focus is placed on the section dealing with the Extent of Documentation (3.2).
- ASOP No. 41, Actuarial Communications. Particular focus is placed on the section dealing with the Actuarial Report (3.3.3),

Resubmission of Actuarial Certifications

Throughout the bid review process, resubmissions may occur for a variety of reasons. After the initial bid submission in June, no substantive changes to the language of the actuarial certifications will be considered without prior permission from CMS Office of the Actuary. The actuarial certification submitted in early June with the initial bid submission will be considered the definitive certification, unless changes are requested by OACT. Any changes

to the certification language would require prior permission from OACT, including changes or additions to any qualifications.

Final Actuarial Certification

Toward the end of the CY2008 bid review process (likely in August), each plan will be required to resubmit a final actuarial certification. As indicated in the previous section, no material changes to the certification language will be considered, without prior permission from OACT. The actuarial certification submitted in early June with the initial bid submission will be considered the definitive certification.

The final certification must only be updated for the following items:

- Date of the signed certification.
- Date BPT prepared (see worksheet 6 of MA BPT, worksheet 7 of PD BPT).
- HPMS upload version #.
  The version number can be found in HPMS under:
  HPMS > Plan Bids > Bid Reports > 2008 > Bid Status History Report
  (See fourth column of the report; header is "Version")

The resubmission of a final actuarial certification is necessary as resubmissions are likely to occur throughout the bid review process and the final package submitted to CMS must be accompanied by an actuarial certification. A final signed actuarial certification needs to be uploaded to HPMS before contracts/Benefits Attestations are signed.

The identifying information above are identifiers that will be used by the plan and CMS as part of the quality control process of bid submissions. These identifiers should direct the certifying actuary to ensure that the actuarial certification is applicable to the final benefit package submitted and the pricing for these benefits is appropriate.

Plans are not longer required to resubmit certifications repeatedly throughout the bid review process during resubmissions. CMS will collect an actuarial certification with the initial bid submission in June, and then require a final certification at the end of the bid review process with updated bid submission identifiers (described above).

Required Elements

The certification *must* include the following information:

- Signature of the certifying actuary. CMS requires that the certification uploaded to HPMS must contain an electronic signature.
- Name of the certifying actuary, title, employing firm, contact information, credentials, qualifications, and relationship of the actuary to the organization submitting the bid. As indicated at the beginning of this appendix, the certifying actuary must be a member of the American Academy of Actuaries (MAAA).
- The date of the certification.
- The specific contract, plan ID(s), and segment ID(s) associated with the certification.
- The Contract Year of the bid(s) contained in the certification.

- Indication of whether the certification applies to the Medicare Advantage bid, the Prescription Drug bid, or both.
- The date that the bid pricing tool was prepared (must match the date entered on BPT Worksheet 6 for MA and Worksheet 7 for PD).
- The upload version #, assigned by HPMS, that identifies the benefit package and bid uploaded to HPMS. The certifying actuary should be made aware of any changes to the PBP via resubmission (i.e., after the initial bid submission). The version number can be found in HPMS under:
  HPMS > Plan Bids > Bid Reports > 2008 > Bid Status History Report
  (See fourth column of the report; header is "Version")
- Specification that the certification complies with the applicable Federal laws, rules, and *instructions* and is based on the "average revenue requirements in the payment area for an [Medicare Advantage/Prescription Drug] enrollee with a national average risk profile."
- Attestation of the reasonableness of the data and assumptions for the plan's benefit package (PBP).
- In accordance with ASOP No. 8, the actuary should consider the business plan for the organization as part of the setting of assumptions and methodologies used in the bid.
- Attestation that the bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries and that the bid complies with the appropriate ASOPs.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this reliance must be disclosed in the certification. Any reliance must be in accordance with ASOP No. 23.
- Limitations and qualifications.

Sample Language

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

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

Organization Name:		Health One			
Bid ID (Contract - Plan - Segment)	Cert. For MA bid?	Cert. For PD bid?	MA Date Bid Prepared (MA w6)	PD Date Bid Prepared (PD w7)	HPMS upload version #

H9999-001-00	Y	Y	5/30/2007	5/15/2007	1
H9999-002-00	Y	Y	6/1/2007	6/2/2007	5
H9999-003-00	Y	N	5/28/2007	5/28/2007	2

I hereby certify that, to the best of my knowledge and judgment, the entire bids identified in this certification are in compliance with the appropriate laws[1], rules[2], and instructions and comply with the appropriate Actuarial Standards of Practice. In making this statement, I certify that:

- In accordance with Federal law, the bid is based on the "average revenue requirements in the payment area for an [Medicare Advantage/Prescription Drug] enrollee with a national average risk profile."
- The data and assumptions used in the development of the bid are reasonable for the plan's benefit package (PBP).
- The data and assumptions used in the development of the bid are consistent with the organization's current business plan.
- The bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

In preparing this bid, I relied upon others for certain data and assumptions. I have reviewed this data for reasonableness and consistency, in accordance with ASOP No. 23. I have uploaded supporting documentation that contains further information describing the nature of these data and assumptions.

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

Sincerely,

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

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

[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.

Appendix B – Supporting Documentation

In addition to the bid form and actuarial certification, organizations must provide CMS with supporting material. 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.

In order to complete the MA bid form, MAOs must complete a series of calculations and enter the results in the appropriate worksheet. Therefore, it is required that any relevant supporting information be summarized and included with the bid submission to CMS. Supporting materials are to be in electronic format (i.e., Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation.

Organizations often upload numerous documents that contain supporting documentation. To expedite the bid review process, organizations should upload a "cover sheet" listing all of the uploaded files. This cover sheet would serve as a "table of contents" that would enable CMS to quickly identify the various files that have been submitted.

Note that multiple files can be submitted to HPMS at one time by using "zip" files, whereby multiple files are zipped into one file. Also, files can be uploaded to multiple plans in HPMS by using the CTRL key when selecting plans.

To expedite the bid review process, CMS strongly encourages plans to upload supporting documentation *with the initial bid submission to HPMS*.

Supporting documentation must be clearly labeled and easily understood by CMS reviewers. The documentation for the bid must include quantitative support and details, rather than just narrative descriptions of assumptions.

Required Documentation

Initial Bid Submission. CMS requires that the following supporting documentation be uploaded *with the initial bid submission*:

- A signed electronic actuarial certification (see Appendix A for more information on the required elements of actuarial certifications).
- Support for the credibility assumptions (Worksheet 2), if the assumptions differ from the CMS guidelines included in these instructions.
- Support for the manual rate development (Worksheet 2), if a manual rate is used.
- Support, at the benefit level, for any significant projected allowed costs (i.e., PMPM > $5.00) for Non-Covered services (Worksheet 2, lines l through s, column o).
- Detailed description of the process used for adjusting cost sharing due to maximum out-of-pocket limits (Worksheet 3).
- Support for the cost sharing test if a plan does not fall within the allowable limit (Worksheet 4, Section III).

- Support for the development of the Contract Year ESRD "subsidy" for Basic Benefits (Worksheet 4).

- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans, if used. (Indicated in the General Information section of Worksheet 1.)

- Support for the development of plan-provided ISAR factors (Worksheet 5), if used (Regional PPOs only). A description of the methodology and data source(s) used to calculate the ISAR scale(s) must be included. The factors must reflect the requirements for medical expense, non-benefit expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (i.e., non-benefit expense and gain/loss margin) that were assumed in the development of the factors.

- Support for the development of projected risk scores (Worksheet 5).

Upon Request by CMS Reviewers. The following items are not required to be included with the initial bid submission, but must be available upon request, and will be reviewed at audit:

- Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
- Support for projection assumptions (Worksheet 1).
- Information regarding the base period member month distribution, if more than four plans comprise the base period data (see Worksheet 1, Section II line 5).
- Support for cost sharing utilization assumptions and plan level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-Covered and A/B Mandatory Supplemental benefits (Worksheet 4).
- Support for non-benefit expense assumptions (Worksheet 4). This documentation could include further analysis of non-benefit expense categories (separating claim adjudication, network management, customer service, etc.). In addition, distinctions between start-up versus ongoing costs and fixed versus marginal costs may be examined by CMS.
- Justification of the margin for bids with relatively large or unreasonable projected gains/losses relative to other bids, including other bids submitted by the same organization. Examples of such justification are (i) illustration of return on investment /equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other actuarial support. The development of the margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income (Worksheet 4).
- Non-benefit expenses and gain/loss margin for Optional Supplemental Packages that are not consistent with the assumptions of the Basic Bid (Worksheet 7).

- Communication between CMS reviewers and the organization throughout the bid review process (i.e., e-mail communication).
- Additional information will be requested by CMS reviewers, as needed.

Appendix C – Part B-Only Enrollees

Medicare beneficiaries with Medicare coverage only under Part B cannot elect an MA plan after December 31, 1998 unless they are members of employer or union groups.

However, Medicare beneficiaries (with Part B coverage under Medicare) who were Medicare enrollees of a Section 1876 contractor on December 31, 1998 shall be considered to be enrolled with that organization on January 1, 1999 if the organization had an MA contract for providing benefits on the latter date. Health benefit coverage that MA organizations provide to such remaining Part B-only enrollees constitutes a separate MA plan (which requires a separate bid submission).

CMS encourages MA organizations to submit as few plans as possible for their pre-1999 Part B-only members, rather than duplicating each of their A/B plans. In fact, an MA organization can submit one plan for all its pre-1999 Part B-only members under an MA contract if they are in the same type of plan. In addition, if the plan is offering the pre-1999 Part B-only members the same benefits at the same price as those offered to A/B members (i.e., members eligible for both Part A and Part B of Medicare), the plan is not required to submit a separate bid for the Part B-only members.

On the other hand, MAOs that enroll Medicare beneficiaries with Part B-only coverage in an employer-only group plan must prepare a Part B-only bid. If a separate B-only plan is not created, the CMS managed care payment system will reject any enrollments submitted on behalf of individuals without Part A.

MAOs should prepare Part B-only bids in much the same way as those prepared for Part A/B members.

Appendix D – Medicare Advantage Products Available to Groups

(Employer Groups and Union Groups)

Organizations have two options for offering Medicare Advantage (MA) products to members of employer and union groups: individual-market plans and employer/union-only group waiver plans (i.e., "800-series" plan IDs).

Individual-Market Plans ("mixed enrollment" plans)

Essentially, MAOs may either offer their individual-market products without modification or tailor the products to specific employer and union groups through two types of allowable customization: "actuarial swapping" or "actuarial equivalence."

***Actuarial Swaps*.** If requesting the actuarial swapping category of customization, identify in the supporting documentation both the benefits that might be swapped during negotiations with employers and/or unions and the MA plan covering those benefits. You need to identify only those benefits in your bids that are candidates for swaps. You do not need to identify the benefits that you *might* swap for the candidates. When you make specific swaps in negotiations with employers or unions, in the context of the CMS general approval of your candidates, you can do so without obtaining further approval from CMS for the actual swaps.

Actuarial Equivalence. If you request the actuarial equivalence category of customization allowable for employer and union groups, provide the following information as supporting documentation:

- The cost sharing amounts you intend to change and the MA plan containing the cost sharing.
- Any modification to the premium you will charge.
- Any improvement in the benefit related to the changed cost sharing.

Please retain in your files a package of documents with computations supporting the proposed changes under these two types of allowable customization. Do not include those packages of documents in the backup material you send to CMS.

Employer-only or Union-only Group Waiver Plans (EGWPs)

The Medicare Modernization Act (MMA) provides employers and unions with a number of options for providing Medicare coverage to their Medicare-eligible active employees and retirees. Under the MMA, those options include making special arrangements with MA organizations to purchase customized benefits for their active employees and retirees or contracting directly with CMS to sponsor a Medicare Advantage plan.

Under Sections 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for these kinds of arrangements that "hinder the design of, the offering of, or the enrollment in" these employer or union-only sponsored group plans. CMS may exercise its statutory waiver authority for two basic types of MA plan entities: (1) MA organizations

that offer or administer employer/union-only sponsored group waiver plans ("EGWPs" or "employer-only group plans"); and (2) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan ("Direct Contract" EGWPs).

CMS has issued guidance waiving or modifying a number of requirements for these entities. CMS waiver guidance is located at: http://cms.hhs.gov/EmpGrpWaivers .

CMS also has issued guidance on employer and union MA contracting in Chapter 9 of the *Medicare Managed Care Manual:* http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326 .

As described in Chapter 9 of the *Medicare Managed Care Manual* (MMCM), organizations may offer Medicare Advantage plans that are *only* available to employer and union groups. These products must follow all Medicare Advantage bidding requirements, except those that are specifically waived per Chapter 9 of the MMCM. The following are some of the key features to be reflected in employer-only group bids:

- Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for the contract year. These assumptions include, but are not limited to, the following: risk scores, geographical distribution of enrollees, benefit package, non-benefit expenses, and gain/loss margins.

- The cost sharing priced in worksheet 3 must correspond to that contained in the Plan Benefit Package (PBP). The PBP can either be prepared using the expected composite benefit plan or may be based on the Medicare fee-for-service benefit provisions.

- Generally, CMS would expect that actuarial and financial assumptions supporting each employer-only group bid would bear a reasonable relationship to corresponding individual-market products offered by the organization. Significant differences between corresponding employer-only group and individual-market products (such as the relationship of the bid to the benchmark) must be based on actual credible experience. Organizations must provide documentation in support of differences in actuarial/financial assumptions between the corresponding products.

- There is no requirement to charge the filed MA basic and supplemental premium to each employer or union group that enrolls in the plan. However, the average premium charged, weighted by enrollees, across all groups enrolled in the plan should correspond to (i.e., be consistent with) the filed premium.

- The following are the guidelines for rebates:

    - Similar to CMS' payment on behalf of beneficiaries enrolled in individual market plans, a uniform rebate amount will be paid by CMS on behalf of each individual enrolled in an employer-only group plan.

    - The allocation of rebates may vary employer to employer within the employer-only group plan. (The bid form contains one allocation).

    - Employer-only group bids cannot reflect an allocation of rebates to Part D basic premium or Part D supplemental premium.

- Part B premium buydowns (i.e, rebate allocation) must be the same for all enrollees within the same employer-only group plan.

- Consistent with individual-market bids, rebates allocated to reduce members' Part B premium will be transferred to the Social Security Administration, not the MA organization.

- All groups enrolled in an employer-only plan with supplemental A/B rebates (both reduction in A/B cost sharing, and additional benefits) must receive supplemental benefits equal to the amount of the A/B rebate allocation. However, A/B supplemental benefits provided to each employer may be customized. Further, MA organizations may use the field V. 1. of Worksheet 4, *PMPM for additional/unspecified MS benefits*, to account for A/B supplemental benefits that are likely to be customized.

- All rebates must be accounted for, and used only for the purposes provided in law. Documentation must be retained by the employer-only group plan that supports the use of all of the rebates on a detailed basis.

The Call Letter may contain additional guidance regarding employer-only group bidding.

Appendix E – Plans Serving Qualified Medicaid Beneficiaries (QMBs)

The following guidance was released in the CY2007 Call Letter regarding plans serving QMBs.

Bidding Instructions for Plans Serving Qualified Medicare Beneficiaries

The MA bidding rules specify that the development of contract year total allowed medical expenses, which are reflected on a per-member per-month (PMPM) basis, include the sum of projected plan reimbursements and enrollee cost sharing. The plan reimbursements reflected in the bid must reflect the actual projected plan payments to providers for health care services.

The basis of each category of enrollee cost sharing is the product of per-service requirements, as reflected in the plan benefit package (PBP), and expected utilization. MA plans subtract from total allowed medical expenses the PMPM value of fee-for-service Medicare actuarially equivalent cost sharing.

Section 1902(a)(10)(E)(i) of the Act requires State Medicaid Agencies to pay cost sharing amounts on behalf of Qualified Medicare Beneficiaries (QMBs). (The term QMB is defined in section 1905(p)(1) of the Act.) Paragraphs (n)(1) and (2) of section 1902 of the Act provide authority, when certain conditions are met, for State Medicaid agencies to reduce or eliminate cost sharing amounts on behalf of such beneficiaries through the State Medicaid Plan. In such cases paragraph (n)(3) exempts QMB beneficiaries from paying Medicare Advantage plan Medicare cost sharing (see section 1905(p)(3)) and requires providers to accept the sum of Medicare Part C payments and any amount paid (or reduced/eliminated) by the State Medicaid Agency as payment in full for the item or service in question.

The MA Organization determines what level of cost sharing it wishes to have for any given MA plan. This is true for all plans, including those that primarily serve QMBs. The MA Organization may determine the desired level of plan cost sharing irrespective of whether a state Medicaid agency will pay the plan or its providers some, all or none of this cost sharing for QMBs.

These instructions clarify that the cost sharing component of the bids filed on behalf of QMBs must reflect plan cost sharing, as reflected in the PBP. That is, the cost sharing component of allowed medical expenses will include all cost sharing charged by the plan, even though some or all of that cost sharing may not be paid to the plan or its providers because of the application of SSA Section 1902(n). In other words, regardless of whether a state Medicaid agency pays on behalf of a QMB some, all, or no cost sharing — either directly to the provider, or through a contractual arrangement with the MA Organization — the full level of plan cost sharing must be reflected in the development of allowed costs (MA bid Worksheet 2) and enrollee cost sharing requirements (MA bid Worksheet 3). Please note that this guidance is not intended to limit an MA Organization's flexibility to determine how much to pay its providers or how to determine projected payments to providers.

For example, an MA plan that charges cost sharing that is actuarially equivalent to full Medicare fee-for-service will include the PMPM equivalent of full Medicare fee-for-service

cost sharing in their allowed costs. Per SSA Section 1902(n), CMS will consider Medicaid payments made on behalf of any QMBs enrolled in this MA plan as meeting the cost sharing obligation of these individuals.

This guidance does not change the requirement that plan cost sharing in the PBP must be the same for all enrollees. Therefore, if an MA Organization offers a plan that serves both QMBs and non-QMBs and includes cost sharing that is less than that charged in Medicare fee-for-service, the cost sharing component of the plan's allowed costs must reflect this plan-level cost sharing for both QMBs and non-QMBs.

Reimbursements of QMB cost sharing by Medicaid State Agencies may take the form of a payment to either MA Organizations or the providers. The reimbursements reflected in the allowed cost component of each bid must reflect the projected payments from the MA Organization to the providers, less any projected payments from Medicaid agencies to the MA organization for cost-sharing. Payments made directly from Medicaid State Agencies to providers should not be netted from allowed costs. To the extent that the provider does not collect from the State Medicaid agency (either directly or through the MA Organization) the full amount of cost sharing, CMS does not consider the plan to be waiving the Part C cost sharing amounts.

These instructions are consistent with last year's QMB bidding instructions and there is no change intended.

Appendix F – Rebate Reallocation and Premium Rounding

The following guidance was released in the CY2007 Call Letter regarding the rebate reallocation period and premium rounding.

Rebate Reallocation and Premium Rounding

This guidance is organized into five sections: Section I presents terminology. Section II discusses rules for rebate reallocation by plan type. Section III provides guidance for changes that can be made to funding of Part D and Part C benefits during the rebate reallocation period. Section IV covers several additional topics, and Section V discusses premium rounding rules.

I. Terminology

Rebate Reallocation Period. Following 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, MA organizations may reallocate Part C rebate dollars in the MA bid pricing tool for certain MA plan bids (BPT). Rebate reallocation is one aspect of the annual MA bid negotiation process that takes place in August. Rebate reallocation is required for some MA plans, is optional for others, and is not allowed for certain plans, as discussed in this guidance.

The rebate reallocation period is about five to seven business days. After changes to rebate allocation and/or premium rounding, the MA organization will re-submit the bid package via HPMS. CMS will announce the exact dates of the rebate reallocation period at the time we publish the Part D and MA regional plan amounts.

Target Part D basic premium. The target Part D basic premium is the Part D basic premium net of any Part C rebate dollars that were applied to reduce (buy down) the premium. MA organizations will provide the target Part D basic premium in the initial June bid submission via the bid pricing tools. Once CMS publishes the national average Part D bid and other amounts, CMS calculates each plans' actual Part D basic and actual total plan premium. MA organizations that are required, or that can opt, to reallocate rebate dollars to return to the target Part D basic premium can do so only during the rebate reallocation period.

Standard Part B premium. The standard Part B premium is the full-subsidy monthly Part B premium amount. Beginning in 2007, beneficiaries meeting specified income thresholds will have a monthly adjustment amount added to the full-subsidy amount. Given the MA requirement of uniform premiums within a plan, effective 2007, the lowest Part B premium an MA plan can offer is the estimated standard amount net of rebates. This may not result in a zero Part B premium for all enrollees. OACT will continue to provide the estimate of the standard Part B premium each year for bidding purposes.

II. Rebate Reallocation Rules – When Can Rebate Be Reallocated?

II.A. MA-only Plans.

For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final CY premium, as these plans are not affected by calculations of the Part D national average bid or the MA regional plan benchmarks. Thus, the rebate reallocation period does not apply to local MA-only plans. That is, MA organizations will **not** have an opportunity during the rebate reallocation period to resubmit local MA-only plan bids to round their premiums. If an MA organization desires a "whole-dollar" premium, it should be submitted as such in the initial June submission.

II.B. Local and Regional MA-PD Plans with No Part C Rebate Dollars.

Local and regional MA-PD plans with no Part C rebate dollars would only participate in the Rebate Reallocation Period to round premiums in order to adjust the Part D basic premium resulting from application of the Part D national average bid. See Section III.B.4. for the case where the plan's target Part D basic premium is the Low Income Premium Subsidy (LIPS) amount.
Regional MA-PD plans with no Part C rebate dollars in the initial June bid submission that end up with rebate dollars after comparison of the final MA regional benchmark to the plan bid must participate in rebate reallocation to apply those rebate dollars to fund reduction(s) in supplemental benefit premiums, a Part B premium reduction, and/or a return to the target Part D basic premium.

II.C. Local and Regional MA-PD plans that Allocated Excess or Insufficient Part C Rebate to the Part D Basic Premium

Organizations must provide in the MA BPT the target Part D basic premium. The MA organization has two options for specifying the target Part D basic premium: (1) The low-income premium subsidy benchmark for the region (i.e., whatever amount is equivalent to a zero premium for full subsidy low-income beneficiaries); or (2) a specific dollar amount net of Part C rebates (e.g., zero).

Once CMS has announced the national Part D Base Beneficiary Premium, the resulting Part D basic beneficiary premium may be higher or lower than the plan's target premium. If more rebate dollars were allocated to achieve the plan's target premium than are actually needed, this "excess" allocation results in premium lower than the target premium. This includes the possibility that the resulting premium is a negative number. Conversely, if none of the Part C rebate dollars were allocated to achieve the plan's target Part D basic premium or if not enough rebate dollars were allocated to achieve the plan's target premium, this "insufficient" allocation results in a premium is higher than intended.

Below are the rules for addressing excess and insufficient rebate allocation to the Part D basic premium.

> **II.C1. Rebate reallocation to adjust the Part D basic beneficiary premium (net of rebate) must return to the target premium provided in the initial June bid submission. We will not accept a partial return to the target premium except in the following situation: where the plan intends to return to the target premium and all of the rebate has been reallocated to reduce the Part D basic premium, but the resulting premium is still greater than the target premium.**
>
> **II.C2. If the Part D basic beneficiary premium (net of rebate) is less than zero, rebate reallocation is required.**

The amount of rebate allocated to buy down the Part D basic premium cannot exceed the amount of the pre-rebate premium. Therefore, if premium resulting from application of the National Average Monthly Bid Amount and the Base Beneficiary Premium is negative, the "excess" rebate allocated to buy-down the Part D basic premium must be reallocated to buy-down the Part C or Part D supplemental premiums or the estimated Part B standard premium, in order to return to the target premium.

Example II.C2: Required Rebate Reallocation, given "Excess" Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	$36
	Identify target premium (post-rebate premium)	$0
	Determine rebate amount to apply to pre-rebate D basic premium to "buy down" to target	$36
August – Part D benchmarks published	Outcome of nat'l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	$34 -$2 [$34-$36]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	$34 [$34 – 0]
	Calculate "excess" rebate [June rebate – August rebate]	$2 [$36-$34]
Rebate Reallocation Required	MA organization must reallocate $2 of "excess" rebate to other benefits to return to target premium of $0	

In example C2 above, the required change is the shift from a $36 to a $34 rebate allocation to the Part D basic premium in order to return to the target premium of $0.

II.C3. Rebate reallocation to reduce the premium for Part C or D supplemental benefits is optional if the Part D basic beneficiary premium (net of rebate) is lower than the target premium but not less than zero.

The MA organization has two options: leave the final Part D basic premium (net of rebate) unchanged (i.e., at the level resulting from application of the National Average Monthly Bid Amount and the Base Beneficiary Premium); or reallocate rebate to fund other portions of the plan benefit package in order to return to the target D basic premium. Rebate can be reallocated to reduce beneficiary premiums for the Part C and D supplemental benefits.

If the MA organization elects to allocate the "excess" rebate dollars to the other benefits, the final Part D basic premium must be the target premium. That is, we will not accept a partial return to the target premium (see rule C1). Thus, in example C3 below, if the MA organization does not want to maintain the August post-rebate premium of $15, only a return to $20 is acceptable, not $18.

Example II.C3: Optional Rebate Reallocation, given "Excess" Initial Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	$35
	Identify target premium (post-rebate premium)	$20
	Determine rebate amount to apply to pre-rebate D basic premium to "buy down" to target premium	$15
August – Part D benchmarks published	Outcome of nat'l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	$30 $15 [$30-$15]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	$10 [$30-$20]
	Calculate "excess" rebate [June rebate – August rebate]	$5 [$15-$10]
Rebate Reallocation Options	(a) No rebate reallocation; leave at post-rebate D basic premium of $15.	
	(b) Reallocate $5 of "excess" rebate to other benefits to return to target premium of $20	

II.C4. Rebate reallocation from the Part C or D supplemental premiums to the Part D basic premium in order to meet the target premium is <u>optional</u> if the Part D basic beneficiary premium (net of rebate) is higher than the target premium.

The MA organization has two options: leave the final Part D basic premium (net of rebate) unchanged (i.e., at the level resulting from application of the National Average Monthly Bid Amount and the Base Beneficiary Premium); or reallocate rebate that had been applied to reduction of Part C and D supplemental premiums or the estimated Part B standard premium toward the Part D basic premium, in order to return to the target D basic premium.
If the MA organization does elect to reallocate additional rebate dollars from other benefits, the final Part D basic premium must be the target premium (see rule C1). Thus, in example C4 below, if the MA organization does not want to leave the August post-rebate premium of $25, only a return to $20 is acceptable, not $23.

Example II.C4: Optional Rebate Reallocation, given "Insufficient" Initial Allocation

June - initial bid submission	Estimate pre-rebate D basic premium	$35
	Identify target premium (post-rebate premium)	$20
	Determine rebate amount to apply to pre-rebate D basic premium to "buy down" to target premium.	$15
August – Part D benchmarks published	Outcome of nat'l Part D average bid and base premium: August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	$40 $25 [$40-$15]
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	$20 [$40-$20]
	Calculate "insufficient" rebate [August rebate to achieve target premium – June rebate]	$5 [$20-$15]
Rebate Reallocation Options	(a) No rebate reallocation; leave at post-rebate D basic premium of $25.	
	(b) Reallocate $5 of rebate from other benefits to the Part D basic premium to increase total rebate to $20, thus buying the $40 premium down to the target premium of $20.	

II.C5. Regional MA plans also must adjust rebate allocation to account for any increase or decrease in total rebate dollars.

Once CMS has determined the MA regional benchmarks, there may be an increase or decrease in the total rebate dollars in a regional plan bid. The allocation of rebate dollars to fund the premium for Part C or Part D basic or supplemental benefits or the estimated Part B standard premium reduction must be revised to reflect the new total.

Example II.C5: Regional Plan Decrease in Total Rebate combined with "Excess" Initial Allocation to Part D Basic Premium

June - initial bid submission	Estimate total rebate dollars	$55
	Estimate pre-rebate D basic premium	$35
	Identify target premium (post-rebate premium)	$20
	Determine rebate amount to apply to pre-rebate D basic premium to "buy down" to target premium.	$15
August – Part D and MA regional benchmarks published	Outcome of nat'l Part D average bid and base premium: Final total rebate dollars August pre-rebate D basic premium August post-rebate premium, applying June rebate allocation	$53 $30 $15 [$30-$15]
	Identify change in amount of total rebate	-$2
	Identify rebate allocation needed to move August pre-rebate premium to target premium [August pre-rebate – June target]	$10 [$30-$20]
	Calculate "excess" rebate [June rebate – August rebate]	$5 [$15-$10]
	Reconcile reduced total rebate with "insufficient" D basic allocation	$3 [$5-$2]
Rebate Reallocation Options	(a) Leave D basic premium at post-rebate premium of $15. Subtract $2 of rebate from other benefits to adjust for reduced total rebate	
	(b).Return to target premium of $20. Allocate $3 of rebate to other benefits.	

Section III. How Can Rebate Be Reallocated: Changes Allowed to Funding of Benefits during Rebate Reallocation Period

III.A. Changes Allowed to Funding of the Part D Basic and Supplemental Benefits

During the rebate reallocation period, rebate dollars not used to reach the target premium for basic Part D coverage may be used to buy down the Part D supplemental premium. However, no modifications are allowed to the benefit design or pricing of the Part D basic benefit or the supplemental benefit offered under the "enhanced alternative" design. Changing the Part D benefit design would affect projected reinsurance due to the change in induced demand for basic Part D benefits. This change in reinsurance has an impact on the pricing of basic Part D benefits and, in turn, affects both the National Average Monthly Bid Amount and the Base Beneficiary Premium. The National Average Monthly Bid Amount and the Base Beneficiary Premium can not be recalculated after being announced; thus, there can be no change in Part D benefit design.

Specifically, this prohibition includes the rule that no changes are allowed to the allowed costs, administrative costs, or gain/loss margin in the Part D basic and supplemental benefits.

III.B. Allowed to Funding of the Part C Supplemental Benefits

The Part C mandatory supplemental benefit includes additional items and services not covered by Medicare and reductions in cost sharing for Part A/B items and services from levels actuarially equivalent to average cost sharing under original Medicare. During the

rebate reallocation period, for a plan with "excess" rebate, an MA organization could further buy down the initial Part C supplemental premium or could add new non-drug benefits (e.g., a vision benefit) to the Part C supplemental package and then buy down the new Part C supplemental premium to the initial level. Significant changes to the Part C benefits will result in additional benefit reviews. No changes in Part D benefits or pricing will be accepted.

CMS does not expect and will not allow MA organizations to substantially redesign Part C supplemental benefits during the rebate reallocation period. We expect only marginal adjustments during the rebate reallocation period, and we will evaluate reallocations for differences in materiality.

> Example: acceptable change in supplemental cost sharing. After application of the National Average Monthly Bid Amount and the Base Beneficiary Premium, an MA-PD plan's Part D basic premium shifts from $0 to -$3, which means it has credited $3 of rebate where it is not needed. Rebate reallocation is required. The MA organization may decide to reallocate this $3 to buy-down the cost of a benefit in the Part C mandatory supplemental package.
>
> However, we do not expect the MA organization to accomplish reallocation by moving $15 out of A/B cost sharing reductions and moving $18 into the additional benefit. We would consider this to be a substantial redesign of the supplemental benefit.

III.B1. Administrative costs and gain/loss margins.

If the value of non-drug additional benefits is being increased as a result of reallocating rebate, there will be changes in the supplemental administrative costs and the gain/loss margin that reflect the new level of the benefit. Administrative costs and the gain/loss margin are allocated proportionately. Therefore, we generally expect only minor changes to administrative costs and margins.

III.B2. Elimination of a Part C supplemental benefit.

To return a MA-PD plan with insufficient rebate to the target Part D basic premium, the MA organization could eliminate a Part C supplemental benefit. To return a regional plan with a decrease in the total amount of rebate to the exact amount of total rebate, the MA organization could, for example, eliminate from the Part C supplemental benefit package the coverage of a non-Medicare covered item or service.

The value of the added or eliminated Part C supplemental benefit should match the amount of rebate that must be shifted to return to the Part D target premium. For a regional plan, the value of added benefits should match the net shift in total Part C rebate dollars due to an increase or decrease in those total rebate dollars after application of the regional benchmark and/or returning to the Part D target premium.

We reiterate that we do not expect substantive redesigning of the Part C supplemental package. For plans with excess rebate, we would not expect the MA organization to eliminate one additional benefit and add another additional benefit.

III.B3. First-time allocation of rebate dollars to the Part D basic premium during the rebate reallocation period.

Some MA-PD plans with Part C rebate dollars may have opted in the June bid submission to not allocate any of the rebate to buying down the Part D basic premium. For these plan bids, if the Part D basic premium after application of the National Average Monthly Bid Amount and the Base Beneficiary Premium ends up lower or higher than the target premium, CMS would allow a return to the plan's target premium. No partial return would be allowed.

In the first situation where the Part D basic premium ends up lower than the target premium, the MA organization may return to the target premium by adding an additional benefit to the Part C supplemental package, including the appropriate level of administrative cost and gain/loss margin. This additional benefit must have a value equal to the difference between the Part D basic target premium and the post-national average Part D basic premium.

For example, if no Part C rebate dollars were allocated to buy-down the Part D basic premium, resulting in a target premium of $25, but the plan's Part D basic premium ended up being $23, the MA organization could add an additional benefit worth $2 pmpm to the Part C supplemental benefit to return to the target premium.

III.B4. MA-PD Plans with no Part C rebate and LIPS as Target Part D Basic Premium

If an MA-PD plan, including a Special Needs Plan, has no Part C rebate and specified that the Low Income premium subsidy amount is the target premium, but ends up with a Part D basic premium above the Low Income subsidy amount after the application of the National Average Monthly Bid Amount and the Base Beneficiary Premium, the plan cannot return to the target premium. The plan cannot have a final Part D premium that is zero for the full subsidy Low Income beneficiaries.

III.C. Changes Allowed to the standard Part B premium reduction.

The other use of rebate dollars allowed under §422.266 is reduction of the Part B premium. During the rebate reallocation period, rebate dollars may be shifted into or away from funding a reduction in the estimated standard Part B premium, under the reallocation rules described in other sections. Note that the maximum amount of rebate that can be allocated to reduce the Part B premium is equal to the amount of the estimated standard Part B premium. OACT will continue to provide the estimate of the standard Part B premium each year for bidding purposes.

Section IV — Miscellaneous Guidance

IV.A. Every plan bid must allocate the exact amount of the plan's total rebate.

The exact amount of the plan's total rebate must be allocated among the various options described above. MA organizations must account for all rebate dollars in a plan's bid. Moreover, the amount of rebate allocated to a supplemental benefit or the Part B standard premium reduction must not exceed the value of that benefit. For example, if the Part D supplemental premium is $50, an MA organization may not allocate more than $50 to buy down that premium. Rebate allocations to the standard Part B premium cannot exceed the estimated amount provided by CMS in the bid pricing tool.

IV.B. MA organizations must meet the §423.104(f) requirement on type of drug coverage offered by certain plans, and must reallocate rebate if necessary to meet this requirement.

In accordance with 42 CFR §423.104(f), MA organizations may not offer an MA coordinated care plan in an area unless either that plan (or another MA plan offered by the same MA organization in the same service area) includes required prescription drug coverage.

Required prescription drug coverage is defined by 42 CFR §423.100 as MA-PD plan coverage of Part D drugs that is either:

> -- Basic prescription drug coverage (i.e., defined standard coverage, actuarially equivalent standard coverage or basic alternative coverage); or
>
> -- Enhanced alternative coverage with no beneficiary premium for the Part D supplemental benefit. An MA-PD plan must apply rebate dollars to reduce to zero the beneficiary premium for the Part D supplemental benefit.

MA organizations are required to comply with this requirement. If necessary, MA organizations must reallocate rebate dollars from other benefits to achieve the required Part D supplemental benefit in the plan.

To restate: MA organizations offering coordinated care plans must offer in an area either (a) a basic-only Part D plan or (b) a basic plus supplemental Part D plan where the supplemental premium equals zero. Failure to meet this requirement will result in the inability to offer a Part D benefit. In addition, for MA organizations offering coordinated care plans, failure to offer a Part D benefit in an area will result in the organization being unable to offer a Part C benefit as well, pursuant to the rules of 42 C.F.R. §422.4(c).

IV.C. Local MA Plan Segments.

The above rules on rebate reallocation apply to bids for local plan segments, with the following clarifications.

The plan's health care benefit package must be the same across plan segments. However, the Part C package can be priced differently across segments, e.g., basic and supplemental premiums and cost-sharing may differ across segments.

Segmentation does not apply to the Part D benefit. The Part D prescription drug benefit must be uniform across a plan's service area; thus it may not vary across segments. The amount of rebate allocated to buy-down Part D premiums, the initial target D beneficiary premium, and the final D beneficiary premium must be identical across the entire service areas.

Section V. Rules for Rounding Premiums

1. The bid pricing tools round the following premiums to one decimal (i.e., to the nearest dime) to comply with premium withhold system requirements: Part C (the sum of basic + mandatory supplemental), Part D basic and Part D supplemental. No pennies are allowed.

Rebate dollars allocated to reduce the Part B standard and Part D premiums are rounded to one decimal.

Rebate dollars allocated to reduce the Part C mandatory supplemental premium are still rounded to two decimal places.

Note: Prescription Drug Plans (PDPs) express their intention to round the Part D premium in the initial June bid submission, because the rebate reallocation period does not apply to

PDPs. In the Part D bid pricing tool, PDPs are permitted to round their premiums to either the nearest $0.10 or the nearest $0.50.

2. Local MA-only plans. For local MA-only plan bids, the plan premium submitted in the initial June bid submission is considered the final premium, as they are not affected by the Part D National Average calculation or the MA regional plan benchmark calculations. Local MA-only plans will **not** have an opportunity to resubmit bids to round their premiums. Therefore, if an organization desires a "whole-dollar" premium, it should be submitted as such in the initial June submission.

3. Regional plans and local MA-PD plans. Regional plans and local MA-PD plans may participate in the rebate reallocation process. During rebate reallocation, MA organizations may round the total plan premium to the nearest dollar (up or down) by increasing or reducing the gain/loss margin for Part A/B benefits, as long as there is an offsetting reduction of no more than $0.50. (The total plan premium is defined at 42 CFR §422.262(b) as the consolidated monthly premium consisting of some combination of the Part C basic and mandatory supplemental premiums and Part D basic and supplemental premiums).

If the plan has rebate dollars, the Part A/B gain/loss margin can be changed to result in an increase or decrease of $0.50 of rebate dollars. Note that in order to account for the 25 percent of savings retained by the Trust Funds for plans with bids below benchmarks, the margin can be changed up to a maximum change of $0.67 since this will result in a change of up to $0.50 in rebates ($0.67 x 75% = $.50).

If the plan A/B bid is equal to or greater than the A/B benchmark, the Part A/B gain/loss margin can be slightly changed to result in a premium increase or decrease of up to $0.50.

The rebate reallocation period is not an opportunity to significantly change the benefit package or the bid. For example, one-half of one percent (0.5%) of revenue is considered by CMS to be a significant amount of the average gain/loss margin, and thus a significant change in the bid.

Examples of rounding.

Example (a): An MA-PD plan has no premium for A/B basic or supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This could happen if: (1) the bid equals the benchmark and no A/B supplemental benefits are offered; or (2) the bid is less than the benchmark, the plan has A/B mandatory supplemental benefits, and applies rebates to reduce the Part C supplemental premium to zero. If the post-national-average-drug-bid total plan premium is $30.42, the MA organization could round the plan premium to $30.00, and slightly reduce the gain/loss margin for Part A/B benefits to result in the $0.42 premium reduction. (The gain/loss margin for Part D benefits may not change.)

Example (b). An MA-PD plan has no premium for A/B benefits or supplemental benefits, and an initial basic Part D premium (target premium) of $30. (This could happen if the bid equals the benchmark and no A/B supplemental benefits are offered or if the plan applies rebates to reduce the Part C supplemental premium to zero). If the post-national average drug-bid results in a total plan premium of $32.42, the MA organization could opt to make a slight reduction in the gain/loss margin for A/B benefits that would result in a $0.42 premium reduction and a premium of $32.00.

The MA organization could not round the premium to anything lower than $32. For example, the organization could not round to a combined premium of $30 by reducing the gain/loss margin to result in a premium change of $2.42. To return to the target premium of $30, the MA organization would have to engage in rebate reallocation. See earlier sections of this appendix for guidance on rebate reallocation.

Example (c). An MA-PD plan has no rebates, and an initial total plan premium of $25. The post-national average drug-bid total plan premium is $26.52. The MA organization can round the premium to the nearest dollar (i.e., $27.00), up to a maximum change of $0.50 by increasing the gain/loss margin accordingly.

Example (d). The target Part D basic premium for an MA-PD plan with A/B supplemental benefits is the Regional Low Income Premium Subsidy amount. After the Part D national average monthly bid amount is calculated, the MA-PD plan ends up with a Part D basic premium of $32.00, which is 40 cents over the Regional Low Income Premium Subsidy Amount of $31.60. The MA-PD plan has the following 3 options.

Option 1. The MA-PD plan can maintain its Part D basic premium of $32.00. The plan's full subsidy eligible beneficiaries will pay a Part D basic premium of $0.40.

Option 2. The MA-PD plan can reallocate 40 cents of the rebates that were allocated to the Part C supplemental premium to its Part D basic premium, thus reducing the premium to the Regional Low Income Premium Subsidy Amount of $31.60. To account for the reduction in rebates applied to Part C mandatory supplemental premium, the MA-PD plan may either increase its Part C supplemental premium by 40 cents or reduce its gain/loss margin appropriately. Non-low income subsidy eligible enrollees would pay a Part D basic premium of $31.60.

Option 3. In order to be able to offer a rounded Part D basic premium to non-low-income-subsidy eligible enrollees, MA-PD plans are permitted in this situation to reallocate A/B supplemental rebates to reduce their Part D basic premium to the nearest whole dollar amount below the Regional Low Income Premium Subsidy Amount. Therefore, the MA-PD plan can reallocate $1.00 of its A/B supplemental rebates to its Part D basic premium, reducing the Part D basic premium to $31.00, the nearest whole dollar amount below the Regional Low Income Premium Subsidy Amount of $31.60. To account for the reduction in A/B supplemental rebates applied to Part C, the MA-PD plan must increase its Part C supplemental premium by $1.00. Please note that in this option, the MA-PD plan forgoes 60 cents in potential Low Income Premium Subsidy dollars per full subsidy eligible beneficiary.

Example (e). An MA-PD plan has 3 segments, with Part C premiums of $51, $76, $110. The post-national-average-drug-bid Part D basic premium is $37.90. To end up with whole- dollar total plan premiums, the MA organization could increase the MA gain/loss margin requirements to increase each Part C premiums by $0.10. When added to the $37.90 Part D premium, the total plan premium for each segment is a whole dollar amount - $89, $114, and $148.

Appendix G – Suggested Mapping of MA PBP Categories to BPT Categories

The Medicare Advantage (MA) Bid Pricing Tool (BPT) contains benefit categories that do not correlate one-for-one with the MA Plan Benefit Package (PBP). The BPT was developed to include a reasonable number of benefit categories for pricing purposes and to provide benefit groupings that are consistent with organizations' accounting and claims systems.

The chart below provides a suggested mapping of the PBP and BPT benefit categories. It was released on March 14, 2005 via HPMS.

This mapping is not intended to represent the only method of reporting benefits in the BPT; rather, it contains one suggested method that may be used. Other reasonable mappings may also be used at the actuary's discretion. The cost sharing reported on Worksheet 3 must clearly identify which PBP benefit service categories are priced in each of the BPT service categories.

HPMS contains a "Medicare Benefit Description Report" with further information regarding the PBP service categories. In addition, the *Medicare Managed Care Manual* may be a helpful resource regarding benefit design.

PBP line #	PBP Service Category	Corresponding BPT Category (Worksheet 3)
1a	Inpatient Hospital - Acute	a1. Inpatient Facility: Acute
1b	Inpatient Hospital - Psychiatric	a2. Inpatient Facility: Mental Health
2	Skilled Nursing Services	b. Skilled Nursing Facility
3	Rehab. Services (CORF)	h5. Outpatient Facility - Other: Other
4a	Emergency Care/Post Stabilization Care	f. Outpatient Facility - Emergency
4b	Urgently Needed Care/Urgent Care Centers	f. Outpatient Facility - Emergency
5	Partial Hospitalization	h3. OP Facility - Other: Observation; or h5. OP Facility - Other: Other
6	Home Health Services	c. Home Health
7a	Primary Care Physician Services	i1. Professional: PCP
7b	Chiropractic Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7c	Independent Occupational Therapy Services	i4. Professional: Therapy (PT/OT/ST)
7d	Physician Specialist Services Except Psych (excl Radiology)	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7d	Physician Specialist Services Except Psych (Radiology)	i5. Professional: Radiology
7e	Mental Health Specialty Services - Non-Physician	i3. Professional: Mental Health
7f	Podiatry Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7g	Other Health Care Professional Services	i2. Professional: Specialist excl. MH; or i6. Professional: Other
7h	Psychiatric Services	i3. Professional: Mental Health
7i	Physical/Speech Therapy	i4. Professional: Therapy (PT/OT/ST)
8a	OP Clinical/Diagnostic /Therapy Radiological Lab Services	h1. OP Facility - Other: Lab
8b	Outpatient X-Ray	h2. OP Facility - Other: Radiology
9a	Outpatient Hospital Services	g. OP Facility - Surgery; or h. OP - Facility - Other (all sub-categories)
9b	Ambulatory Surgical Center Services	g. OP Facility - Surgery
9c	Outpatient Substance Abuse Services	h5. OP Facility - Other: Other

9d	Cardiac Rehabilitation Services	h5. OP Facility - Other: Other
10a	Ambulance	d. Ambulance
10b	Transportation	l. Transportation (Non-Covered)
11a	Durable Medical Equipment	e1. DME/Prosthetics/Supplies: DME
11b	Prosthetics/Medical Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
11c	Diabetes Monitoring Supplies	e2. DME/Prosthetics/Supplies: Prosthetics/Supplies
12	Renal Dialysis	h4. OP Facility - Other: Renal Dialysis
13a	Blood	k. Other Medicare Part B
13b	Acupuncture	r. Other Non-Covered
14a	Health Education/Wellness Programs	q. Health & Education (Non-Covered) or k. Other Medicare Part B
14b	Immunizations	i1. Professional: PCP
14c	Routine Physical Exams	i1. Professional: PCP
14d	Pap Smears and Pelvic Exams Screening	i1. Professional: PCP; i2. Professional: Specialist excl MH; or i6. Professional: Other
14e	Prostate Cancer Screening	
14f	Colorectal Screening	
14g	Bone Mass Measurement	
14h	Mammography Screening	
14i	Diabetes Monitoring	
15	Outpatient Drugs and Biologicals/Prescription Drug	j. Part B Rx
16a	Dental: Preventative Services	m. Dental (Non-Covered)
16b	Dental: Comprehensive Services	m. Dental (Non-Covered)
17a	Eye Exams	n1. Vision (Non-Covered): Professional
17b	Eye Wear	n2. Vision (Non-Covered): Hardware
18a	Hearing Exams	o1. Hearing (Non-Covered): Professional
18b	Hearing Aids	o2. Hearing (Non-Covered): Hardware
19	POS	p. POS

Appendix H - BPT Technical Instructions

The CY2008 BPT Technical Instructions is located in HPMS under:
HPMS Home > Plan Bids > Bid Submission > CY2008 > Documentation > BPT Technical Instructions

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

Appendix I – Red-Circle Validation Edits

The purpose of the "red-circle" validation rules in the bid pricing tool is:

- to highlight *some* of the fields that require data entry by the user (i.e., fields that cannot be left blank), and
- to highlight *some* user-entered data that may be invalid/ inaccurate.

In order to check for errors, you must click on the Circle Invalid Data button  on the Standard Excel toolbar. The validation edits will not be updated automatically – you must run the validation macro to update the red circles. The validation macro will be run each time the BPT is opened and each time the BPT is saved.

Each BPT cell with a validation rule has a "pop-up" box in the BPT that explains the validation rule. The following list contains brief descriptions of the validation rules of the MA Bid Pricing Tool.

Worksheet 1

Section I - General Information
All fields require valid user entry in accordance with these bid instructions (i.e., the specified # of digits, capitalization and valid options). Note that three fields in this section – Plan ID, Segment ID and Region Number - must be entered as text (i.e., include a preceding apostrophe and any leading zeroes).

Section II
Line 1 – Time Period Definition
E14: Incurred From Date: valid date entry (i.e., M/D/YYYY).
E15: Incurred To Date: valid date entry after the incurred from date.
E16: Paid through Date: valid date entry after the incurred to date.

Line 5 – Plans in Base: Valid format of entries in first column (for ex., H9999-001). Percentage of member months in second column must total 100%.

Section III
column f : Utilization types cannot be left blank if annualized utilization/1000 and allowed PMPM are entered in columns g and i. Valid entries vary by service category as indicated in the validations' pop-up messages.

Note that plans that use 100% manual rates must enter utilization types on Worksheet 1 for each service category that annualized utilization/1000 and allowed PMPM are entered in columns i and k of Worksheet 2.

Worksheet 2

column e: Utilization types cannot be blank if annualized utilization/1000 and allowed PMPM are entered in columns i and k. Utilization types must be entered on Worksheet 1 for all bids, including those that are using 100% manual rates.

H39: Projected Experience Rate must be greater than zero if experience credibility (L39) is greater than 0%.

K39: Manual Rate must be greater than zero if experience credibility (L39) is less than 100%.

column l: Experience Credibility must be 100% if projected base data (column h) is used and manual rates (column k) are not used.

column p: Percentage of Services Provided OON require valid user entry (i.e., between 0% and 100%).

line v: Manual rate description is required if manual rate is used.

Worksheet 3

column e: Measurement unit code requires user entry. Valid entries vary by service category as indicated in the validations' pop-up messages.

column h: In-network cost sharing descriptions require user entry if in-network utilization/1000 (or PMPM) and effective copay/coinsurance are entered in columns g and i.

J67: Actual plan level in-network deductible is required if an effective in-network plan level deductible PMPM is entered in column f.
J68: Impact of in-network OOP max must be entered if there is an in-network OOP max in cell D12.

column l: Out-of-network cost sharing descriptions require user entry if out-of-network cost sharing PMPM is entered in column m.

M67: Actual plan level OON deductible is a required entry if plan type is PPO.
M68: Impact of out-of-network OOP max must be entered if there is an out-of-network OOP max in cell G12.

Worksheet 4

P13: Standardized plan cost sharing must be within the allowable limit (i.e., P12 must be less than or equal to P11).

columns h and i: Percentage Covered requires valid user entry (i.e., between 0% and 100%).

G43, G44, G45: Non-benefit expense categories are required user entries and cannot be negative.
G47: Total non-benefit expenses cannot be negative

F60: ESRD member months field requires user data entry (i.e., cannot be left blank).

Worksheet 5

E14: Medicare Secondary Payer adjustment requires valid user entry (i.e., between 0% and 100%).

column b: State/County Codes must be entered as text (i.e., include a preceding apostrophe and any leading zeroes).

G31: Use of Plan Provided ISAR cannot be "Yes" for any plan types other than RPPO.

Worksheet 6

D39, D40, D41, D45, D46, D47, D49: Contact information requires valid user entry (i.e., cannot be left blank).

K16: Maximum premium for Part A package (for Part B Only) cannot exceed maximum value in cell L16.

Q16: If rebate allocation does not equal the CMS estimate in cell E14, then entry cannot equal "Yes".

Critical validations for BPT Finalization and upload:

L25, L26: Rebate allocation cannot be negative and must be less than or equal to the maximum value in column m. Rebate allocation must be rounded to two decimals.

L27: Rebate allocation (input in cell R13) cannot be negative and must be less than or equal to the maximum value in column m. Rebate allocation must be rounded to one decimal.

L28, L29: Rebate allocation (input in cells R35 and R41) cannot be negative and must be less than or equal to the maximum value in column m. Rebate allocation must be rounded to one decimal. Additionally, "800-series" plans and MA-only plans cannot allocate rebates to Part D.

L30: Total sum of rebate allocations must equal the amount of rebates available in cell L23.
L31: Unallocated rebates must equal zero.

R31, R43, R45: MA and Part D Supplemental premiums cannot be negative.

R34, R40: For MA-only plans, Part D premiums must be zero or blank.

D39:D41, D45:D47: Contact information must not be left blank.

R47: MA-PD plans must select a valid target Part D premium from the drop-down menu.

Other critical validations for finalization/upload:
If the Bid Pricing Tool is ever unprotected (via password), the finalization process of the BPT will not be possible. If the BPT is ever unprotected for any reason, the user may have to download a blank BPT and "start over" (i.e., transfer all BPT entries into the protected BPT).

The General Information section of Worksheet 1 will be compared to the corresponding PBP general info for consistency. If any fields are inconsistent, upload of the bid package will not be successful.

The service area (counties) entered in MA BPT Worksheet 5 Section V will be validated against the service area defined by the plan in HPMS.

The Part D premiums entered in Worksheet 6 of the MA BPT must match the premiums calculated in Worksheet 7 of the Part D BPT.

R47: Target premium must be selected from drop-down menu options.

Worksheet 7

column h: Package totals must be greater than zero, if package is offered.

column n: Administrative expenses must be greater than zero, if package is offered.

column q: Member months must be greater than zero, if package is offered.

Two-Year Look-Back

D6, D7: Contract number and organization name require user entry.

F14, F22, F29, F40, F57, G57: Entries cannot be negative.

J14, J15, J16, J17, J18, J29, J30, J31, J40, J41, J51, J52, J53: Require user entries and cannot be negative.

K14, K15, K16, K17, K18, K29, K30, K31, K40, K41, K51, K52, K53: Require user entries and cannot be negative.

K49: Paid Through Date must be a valid entry (M/D/YYYY).

N51, N52, N53, O51, O52, O53: Require user entries and cannot be negative.

Glossary of Terms

The Medicare Advantage program uses a number of terms that have specialized meanings. Many of the terms have been used for several years (e.g., Plan Type) and are generally not included in this glossary. The terms included here are primarily those that came about as a direct result of the Medicare Modernization Act (MMA) or the development of the bid form.

A/B Mandatory Supplemental Benefits. Health care services not covered by traditional FFS Medicare (Parts A and B) that an MA enrollee must purchase as part of an MA plan. The benefits may include reductions in cost sharing for Medicare benefits, non-prescription drug benefits not covered by Medicare, and Part B and Part D premium buy-downs.

A/B Mandatory Supplemental Premium. The premium charged to an enrollee for A/B Mandatory Supplemental Benefits.

Allowed Costs. Medical costs before reduction for member cost sharing. This term is not uniquely associated with the MMA, but it has not previously been used in the Adjusted Community Rate (ACR) form.

Average 1.000 Risk Factor. Representation of an average Medicare beneficiary in terms of demographic and health status, as measured by CMS' risk adjustment models.

Basic Member Premium. The MA premium charged to an enrollee for A/B services, if the standardized bid is above the standardized benchmark.

Covered. An abbreviation for Medicare-Covered services.

EGWP. An abbreviation for Employer/Union-Only Group Waiver Plan (i.e., "800-series" plan). Also known as a group plan or employer-only group plan.

EGWP Extra Benefits. Benefits offered to employer/union-only groups that are above and beyond what is covered in the MA plan.

ISAR. An abbreviation for intra-service area rate. See Worksheet 5 instructions for more information about ISAR.

Local plan. An MA plan other than a Regional PPO plan type. Service areas are defined by county.

MA. An abbreviation for Medicare Advantage.

MAO. An abbreviation for Medicare Advantage Organization.

MA-PD plan. An MA plan that offers prescription drug coverage under Part D of the Social Security Act.

MA Rebate. An amount equal to 75% of Savings.

Manual Rates. Rates that are used when the base period experience data are deemed to be less than fully credible. In such cases, the projected experience rate is weighted with the

estimated costs developed under some other (fully credible) basis in the proportion to which the experience data are deemed credible. The term "manual rates" is not uniquely associated with the MMA, but it is not a term previously used in the Adjusted Community Rate (ACR) form.

Optional Supplemental Benefits. Health care services not covered by Medicare that an MA enrollee might choose to purchase as part of an MA plan.

Plan A/B Benchmark. The Standardized A/B Benchmark multiplied by the plan's projected risk factor (for local plans).

Plan A/B Bid. The amount that the MAO estimates as its monthly required revenue to provide benefits for A/B services (at the plan's projected risk factor).

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

Plan Bid Component. The weighted average of the Regional PPO A/B bids (at 1.000) based on projected enrollments.

Prescription Drug Plan (PDP). Prescription drug coverage that is offered under a policy, contract, or plan that has been approved as meeting CMS requirements and that is offered by an organization that has a contract with CMS.

Regional A/B Benchmark. The Standardized A/B Benchmark multiplied by the plan's projected risk factor (for regional plans).

Regional Plan. A coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire MA regions, as defined by CMS. An MA regional plan (i) must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services, and (ii) must pay for all covered services whether provided in- or out-of-network. Service areas are defined by region.

Reinsurance. A term referring to two different concepts:
In the MA program for A/B services, reinsurance refers to the situation in which an MAO is ceding risk to commercial carriers. Also known as *private reinsurance*.
Under Medicare Part D, reinsurance refers to the Federal Government's coverage of 80% of costs over the catastrophic coverage level.

Savings. The difference between the Plan (or Regional) A/B Benchmark and the Plan A/B Bid (not less than zero).

Special Needs Plan (SNP). Any type of MA coordinated care plan that exclusively enrolls special needs individuals.

Standardized A/B Benchmark. For local plans, the weighted average MA payment rate for the plan's service area based on the plan's projected enrollment. For regional plans, the benchmark is based on the Statutory Component and the Plan Bid Component. The term "standardized" indicates that the benchmark is based on a "1.000" average risk profile.

Standardized A/B Bid. The Plan A/B Bid divided by the plan's projected risk factor (i.e., the bid at a 1.000 risk factor).

Statutory Component. The rate used in calculating the regional benchmark, based on regional rates weighted by Medicare-eligible beneficiaries.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.