OMB Approved # 0938-0944

DRAFT INSTRUCTIONS FOR COMPLETING THE MEDICARE PRESCRIPTION DRUG PLAN BID FORM FOR CONTRACT YEAR 2008

NOTE: Benefit parameters are not updated for contract year 2008.

January 10, 2007

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Introduction

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

The submitted bids will be subject to review and negotiation by CMS. As part of that negotiation, CMS may request supporting documentation for the information included on the bid form. Organizations must be prepared to provide CMS and its representatives with documentation to support the development of their bid on request. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates. CMS requires an actuarial certification to accompany every bid submitted to the CMS Health Plan Management System (HPMS). A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification.

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

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

- For plans with appropriate and credible base period experience (uncommon for CY2007),
    - Report the Medicare base period experience.
    - Illustrate the assumptions used to project the base period costs to the contract year.
- For plans with either partially credible or no base period experience, provide a summary of the manual rates and the techniques used in their development.
- Project the estimated costs for defined standard prescription drug coverage for the contract year, including the estimated Federal Reinsurance and Low Income Subsidy (LIS) amounts.
- Demonstrate actuarial equivalence for any plans to be offered that do not provide defined standard coverage.
- Include an actuarial certification for the bid form executed by a qualified actuary.

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

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

Base Experience

Worksheet 1 should be completed when plans have appropriate base period experience for modeling the Part D benefit. The determination of the appropriateness of a plan's experience must include an evaluation of the whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience must be representative of the benefits that will be offered in the contract period. For example, a plan that will be offering defined standard Part D coverage must have experience for a benefit with a gap in benefits and catastrophic coverage for a population similar to the population they expect to be covering in order to summarize base period experience in Worksheet 1.

CMS expects that most plans will not have appropriate base period experience to be used in completing Worksheet 1 for contract year 2007. As explained later in these instructions, plans without appropriate base period experience must develop manual rates for the pricing tool, using available data adjusted to reflect the expected population and the benefit design that will be offered. For example, a plan that has experience in covering Medicaid dual beneficiaries and wishes to provide a special needs plan covering dual beneficiaries will likely have appropriate base period experience for contract year 2007, since the covered population is comparable to the group that will be offered Part D coverage.

A plan that has appropriate base period data must evaluate the credibility of this data. Although we have not yet established credibility guidelines, we expect prescription drug experience to have a higher level of credibility than medical coverage for a similarly sized group. We expect that actuarial judgment will be exercised in determining the credibility factor for a plan's base period experience.

In summary:

- Plans with fully credible experience must complete all sections of Worksheet 1 and Sections II, III, and V of Worksheet 2.

- Plans with partially credible experience must complete all sections of Worksheet 1 and Worksheet 2.

- Plans with no applicable, fully or partially credible experience must complete Section I of Worksheet 1, and Section IV of Worksheet 2.

Required Sections

Plans must complete different sections depending on the type of coverage that will be offered. The following are the sections that need to be completed for each type of coverage.

All plans must complete Section 1 of Worksheet 1.

<u>Defined Standard Coverage</u>

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

Actuarially Equivalent Standard Coverage

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

Basic and Enhanced Alternative Coverage

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

Actuarial Equivalence

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

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

- The first test ensures that the value of total coverage is at least actuarially equivalent to standard coverage.

- The second test ensures that the alternative unsubsidized value of coverage is no less than the standard unsubsidized value of coverage.

- The third test ensures that the average alternative benefits for beneficiaries with allowed drug costs at the initial coverage limit ($2,400) are no less that the average standard benefits at the initial benefit limit.

- The fourth test ensures that the deductible is no greater than $265. The fifth test ensures that the average alternative catastrophic cost sharing percentage is no greater than under standard coverage. We expect that plans can change the cost sharing provisions, meet the five tests, and provide a basic alternative plan.

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

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

Data in Section II of Worksheet 6 are collected to support an actuarial comparison of the proposed benefit to the defined standard benefit; and are not expected to model all of the aspects of plan design. Lines 1 through 20 summarize all of the expected claims of the proposed benefits, with lines 1 through 10 capturing the claims for individuals with less than $2,400 in annual drug claims, and lines 11 through 20 capturing the claims for individuals with $2,400 or more in annual drug claims. Lines 21through 30 capture the claims for

individuals expected to reach catastrophic coverage, which is $5,451.25 or more in annual drug claims for contract year 2006. Note that the amounts summarized in lines 21 through 30 will be a subset of those summarized in lines 11 through 20.

Plans should follow the instructions carefully in developing cost sharing values for column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the cost sharing elements for the proposed defined standard benefit. For lines 1 through 20, column h captures the cost sharing applicable between the deductible and the initial coverage limit for all claims summarized in columns f and g. This means that column h develops cost sharing without the impact of the deductible, the gap in coverage, and catastrophic coverage. For this purpose, plans should ignore the impact of the low-income cost sharing subsidy. Since column h summarizes the defined standard benefit, the claims reflect cost sharing of 25%. Similarly, items in column h for lines 21 through 30 are developed assuming cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this amount would be the greater of 5% or $2.15 for generic drugs / $5.35 for brand name drugs.

Plans submitting a bid to provide an actuarially equivalent or alternative benefit are required to report the projected utilization on the proposed benefit in Section II, columns i, j, and k. The distributions must be based on the categories determined in the defined standard coverage. For example, rows 1 through 10 must reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,400 in annual coverage based on the defined standard coverage. In other words, the utilization summarized in columns i, j and k is based on the same population summarized in columns f, g, and h.

Plans should follow the instructions carefully in developing the cost sharing values in column k, lines 1 through 20, Section II of Worksheet 6. Values in column k are calculated using the copay and coinsurance structure that the proposed actuarially equivalent or alternative benefit applies to allowed utilization between the applicable deductible and the initial coverage limit. As does column h, column k develops cost sharing without the deductible, any gap in coverage, and catastrophic coverage. Lines 21 through 30 are developed assuming the cost sharing applicable beyond the catastrophic threshold for the actuarial equivalent or alternative coverage.

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

Plans proposing a benefit that has standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on lines 16 and 17, Section III of Worksheet 4:

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

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

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

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

Special Considerations

Part D Payment Demonstration

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

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

Generally, the capitation options replace the typical reinsurance subsidy of 80% of allowed costs that apply after the beneficiary has reached the out-of-pocket threshold of $3,850 of true out-of-pocket payments (TrOOP) with a capitation amount reflecting the actuarial value of that subsidy if it is offered under the defined standard benefit structure. The distinction between the flexible and the fixed options is that catastrophic coverage is required to begin at $5,451.25 of total drug expenditures (consistent with the point at which the beneficiary would have catastrophic coverage under the defined standard benefit) for a beneficiary in the "fixed" option. The flexible option permits catastrophic coverage to begin at any point after the beneficiary has $3,850 of TrOOP spending.

The MA rebate option permits supplemental benefits that fill in the coverage gap to count toward the accumulation of the beneficiary's TrOOP. In this option, as is the case for non-demonstration Part D plans, reinsurance will be paid based on 80% of allowed reinsurance costs after beneficiaries have satisfied their TrOOP requirement. No change to the bidding requirements or bid pricing tool (BPT) is necessary to support plans choosing this option.

It should be noted that a non-demonstration Part D plan that provides supplemental coverage will generally delay the point at which a beneficiary reaches catastrophic coverage. Accordingly, a non-demonstration Part D plan will likely see a shift in allowed costs - from amounts that would be provided under catastrophic coverage for defined standard coverage, to amounts in the coverage gap for alternative coverage. Since the fixed capitation option and the flexible MA rebate option do not delay the point at which a beneficiary reaches catastrophic coverage, there should not be a shift from catastrophic costs to gap coverage costs for these options. For the flexible capitation option, a shift in costs between catastrophic and coverage gap is to be expected.

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

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

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

The following is an explanation of each option:

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

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

Modeling Considerations

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

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

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

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

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

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

Profit Guidance

CMS will review the reasonableness of various components of plan bids, including the profit component, and 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 will 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 will 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.

First Dollar Generic Coverage

Plans that are implementing a deductible that is not applied consistently between categories of drugs (for example, $0 deductible for generic drugs, and $265 deductible for brand drugs) must make several modifications to pricing of this benefit in the BPT. Specifically, Worksheet 5 the BPT requests the proposed deductible. Plans with a non-uniform deductible must enter $0 for the proposed deductible in D6 and F8 in Section IV of Worksheet 5. Plans with a uniform deductible must enter in Worksheet 6 the cost-sharing items for the population with spending under $2,400, and for the population with spending over $2,400 applying the effective cost-sharing by drug class for the interval between the deductible and the initial coverage limit. Plans with a non-uniform deductible must reflect the impact of the brand deductible in the brand cost-sharing categories in addition to the cost-sharing required after the deductible has been satisfied.

Decreased Initial Coverage Limit (ICL)

Plans that are lowering the initial coverage limit (ICL) must still report in lines 3 through 8 of Worksheet 6 all costs and cost-sharing for drug spending up to the defined initial coverage limit in 2007. For plans that are reducing the ICL to $2,000, the amounts in column k must reflect the cost-sharing appropriate up to the $2,000 level plus 100% of costs for drug spending between $2,000 and $2,400. The entries on Worksheet 6 (Scripts Projection) must fit in the specified intervals. For example, for members with allowed drug costs (under defined standard coverage) above $2,400, their entire allowed amounts and scripts are to be entered in the section for persons with expenses above $2,400, regardless of the alternative plan's benefit limit. Note that the section for persons with expenses above $2,400 also

includes amounts for members with expenses exceeding $5,451.25. A member's expenses and scripts are entered in the expense section as projected under defined standard coverage. No matter what expense category a member is assigned under the defined standard benefit, the member must remain in the same expense category under the alternative coverage even if the expense level changes due to the incentive of alternative coverage.

Coverage in Payment Gap

Enhanced alternative coverage can reduce cost-sharing and / or provide coverage for drugs that are specifically excluded from the definition of Part D drugs. While enhanced alternative coverage can fill in some or all of the coverage gaps in the Defined Standard coverage, it cannot affect the true out-of-pocket threshold of $3850 in 2007 (see Payment Demonstration discussion for exceptions). Therefore, reductions in cost-sharing would impact the point at which the member reaches the true out-of-pocket threshold for catastrophic coverage.

Worksheet 1 - Rx Base Period Experience

Overview

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

Section I – General Information

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

Line 1 – Contract Number

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

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the plan being priced in the bid form. Plan IDs contain three Arabic numerals. Please enter all leading zeros. For example, enter “001” for plan number one. If the bid is for an employer-group-only plan, the plan ID must be 800 or higher.

Line 3 – Segment ID

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

Line 4 – Contract Year

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

Line 5 – Organization Name

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

Line 6 – SNP

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

Line 7 – Plan Name

Enter the name of the MA-PD or PDP plan that you are offering to Medicare enrollees. This entry must match what is in the PBP.

Line 8 – Plan Type

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

Type of Plan	Plan Type Code:
Local Coordinated Care Plans:	
Health Maintenance Organization	HMO
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS
Provider-Sponsored Organization w/ State License	PSO State License
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 Plan	PFFS
Continuing Care Retirement Community	
Continuing Care Retirement Community	CCRC
Demonstration Plans:	
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
National PACE	PACE
1876 Cost	1876 Cost
Medical Savings Account	MSA
Prescription Drug Plans:	
Medicare Prescription Drug Plan	PDP
Employer Sponsored Prescription Drug Plan	ESPDP
Fallback Plans	
Fallback Plan	Fallback

Line 9 – Enrollee Type

Select the enrollee type from the drop-down-menu if applicable. Options are “Part B Only” and “A/B.”

Line 10 – PD Region

Enter “Multiple” or National” if applicable, or enter the PD Region from the valid options are listed below:

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

Line 11 – Plan Benefit Type

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

Line 12 – Payment Demo Type

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

Section II – Base Period Background Information

Line 1 – Time Period Definition

Enter the base period experience incurral information on the first two lines. In addition to the incurral dates, enter the “paid through” date. For example, if the incurral period is calendar year 2005, the “incurred from” date is 1/1/2005 and the “incurred to” date is 12/31/2005. If the data reflect payment information through February 2006, then the “paid through” date is 2/28/2006. Note that we do not require that the base time period incurral data be based on a calendar year.

Line 2 – Member Months

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

Line 3 – Credibility

If the base period experience is fully credible, enter “F”; if partially credible; enter “P” .If the plan has no applicable, credible experience, enter "N”.

Line 4 – Risk Score

Enter the plan’s prescription drug risk score underlying the base period data. The CMS drug model risk score must be used, and must be estimated to three decimal places. If the plan risk score is not known, CMS will provide information so that plans can estimate the projected risk score for their population.

Line 5 – Completion Factor

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

Line 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 data for credibility, which is addressed on Worksheet 2 with the manual rate. Examples of different base period data include:

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

Section III – Part D Claims Experience

Section III summarizes the base period experience for Part D coverage. Please note that these data:

- Need not exactly match the benefit plan or service area for the bid (see Section II instructions).
- Reflect either calendar year or other annualized experience.
- Reflect the current best estimate of incurred claims including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin).
- Include total services (both in-network and out-of-network).

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

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

Column d, Lines 1 through 5 – Number of Members

Enter the number of members with total allowed claims in the interval experience period defined for each line. For example, if 7,000 members had allowed expenses between $250 and $2,249, then 7,000 would be entered in line 3 of column d.

Column e, Lines 1 through 5 - Member Months

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

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

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

Column g, Lines 1 through 5 - Total Allowed Dollars

For each line, enter the total allowed dollars for the prescriptions filled in the experience period for the members included in column d. Allowed expenses are defined as ingredient

cost plus dispensing fee, plus state sales tax where applicable, prior to application of any rebates recovered after the point of sale of the prescription.

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

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

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

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

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

For each line, enter the difference between the average paid amount in column i and the amount that would have been entered in column j if the Rx plan had been defined standard coverage.

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

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

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

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

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

This value is automatically calculated by subtracting the values in columns j, k, and l from the value in column i.

Line 6, Columns d through m – Subtotal

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

Line 7, Columns g and i – % OON

For column g, enter the percent of total allowed dollars from line 6 for prescriptions filled out-of-network. For column i, enter the percent of average paid dollars from line 6 for prescriptions filled out-of-network.

Line 8, Column g and Columns i through m – PMPM Values

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

Line 9, Columns i, l, and m – Minus PMPM Rebates

Enter, in each of columns i and l, the PMPM value of rebates received with respect to the claims included in lines 1 through 5. Total rebates should be allocated to the plan using a method that reasonably represents the way in which the rebates were generated, and rebates should be allocated to columns j and m based upon the amount on line 6 for each column. Column m is calculated based upon the entries in the other columns. All rebates and price concessions not used to directly reduce the cost at the point of sale must be included. Rebates and price concessions must be reported in full. Any charges or fees for the administration of rebates or price concessions must be included separately as a component of direct administrative costs.

Line 10, Columns i and m – PMPM Value of Part D as Secondary

Enter in column i the PMPM value of any payments for Part D covered drugs for which Part D is secondary. Column m is calculated based upon column i.

Line 11, Columns I through m – PMPM Net Expenses

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

Line 12, Columns g and i - PMPM Value of Non-Part D Covered D Drugs

Enter the PMPM value of claims for drugs covered by the plan that are not Part D covered drugs. Enter the allowed PMPM in column g and paid PMPM in column i.

Line 13, Column i - PMPM - Rebates on Non-Part D Covered D Drugs

Enter the PMPM value of any rebates allocable to the drug payments included on line 12.

Line 14, Columns i and m – Net PMPM on Non-Part D Covered D Drugs

Column i and m are calculated automatically.

Section IV – PMPM Non-Benefit Expense

This section summarizes the PMPM value of the components of Part D non-Benefit expenses in the base period. The allocation of expenses between basic and supplemental benefits must be allocated proportionately between the cost of the supplemental coverage and the value of the standard benefit.

Enter amounts on lines 1 through 4 of columns e and f. Line 5 and column g are calculated automatically.

Section V – PMPM Premium Revenue

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

Enter amounts on lines 1 through 4 of column e and on line 3 of column f. Line 5 and column g are calculated automatically.

Section VI – PMPM Income Statement Summary

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

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

Worksheet 2 - PDP Projection of Allowed/Non-Benefit

The purpose of this worksheet is (i) to identify the components of trend in the allowed Rx cost for covered Part D drugs and for non-benefit expenses between the base period and the contract period, and (ii) to blend in manual rate information for plans that do not have fully credible base period experience data. The base period information must be consistent with that in Worksheet 1, and the projection information must be consistent with that in Worksheet 3.

Worksheets 2 and 6 develop for a proposed plan, summaries of the distribution of generic, brand name drugs (preferred and non-preferred), and specialty drugs, including allowed amounts and cost-sharing amounts. These summaries assist in determining actuarial equivalence, and are cross referenced with information submitted in the plan's formulary and Plan Benefit Package (PBP). T

Brand Drugs

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

Preferred / Non-Preferred Brand Drugs

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

Generic Drugs

Non-Innovator Multisource Drugs are generic drugs.

Specialty Drugs

The addition of a separate reporting category for specialty drugs is a significant change to Worksheet 2 in the BPT for contract year 2008. Specialty drugs are reported separately under type of script only when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier is designated a specialty tier, (ii) cost sharing associated with that tier is limited to 25% in the initial coverage range, and (iii) only Part D drugs with plan negotiated prices greater than $500 per month may be placed in the tier.

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

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

Section I – General Information

This information is carried forward from Worksheet 1.

Section II – Utilization for Covered Part D Drugs

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

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

Lines 1 through 8, Column f - Allowed per Script

For each type of prescription, enter the average allowed amount per script for scripts filled in the base period. The amount allowed is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable. Do not include rebates and medication or utilization management costs.

Lines 1 through 8, Column g - PMPM Allowed

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

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

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

Lines 1 through 8, Column i - Formulary Change

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

Lines 1 through 8, Column j - Risk Change

For each line, enter the factor that represents the impact of the covered population's change in risk between the base period and the contract period.

Lines 1 through 8, Column k - Induced Utilization

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

Lines 1 through 8, Column l – Other Change

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

Lines 1 through 8, Column m - Total Utilization Change

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

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

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

Lines 9 through 14, Columns e through n

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

Section III – Cost for Covered Part D Drugs

Lines 1 through 8, Column e - Inflation Trend

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

Lines 1 through 8, Column f - Discount Change

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

Lines 1 through 8, Column g - Formulary Change

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

Lines 1 through 8, Column h - Other Change

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

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

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

Lines 1 through 8, Column j -

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

Lines 1 through 8, Column k - Projected Allowed PMPM

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

Lines 9 through 14, Columns e through k

The value is automatically calculated using lines 1 through 8.

Section IV – Projected Allowed PMPM

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

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

Lines 1 through 8, Column n - Manual Rate PMPM

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

Lines 1 through 8, Column o – Credibility

Enter the credibility percentage that is applied to the actual experience to blend the manual experience to produce contract period projections.

Lines 1 through 8, Column p - Blended Allowed PMPM

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

Lines 7 through 14, Columns l through p.

The value is automatically calculated using lines 1 through 8.

Section V – PMPM Non-Benefit Expense

This section identifies the PMPM value of the components of Part D non-benefit expenses. A full reporting of all administrative expense is required in this section, including any administrative expense that may be offset through direct or indirect remuneration. The non-benefit expenses must be shown separately for the following categories:

- Sales and Marketing
- Direct Administration (for example, functions that are directly related to the administration of the program, such as customer service, billing and enrollment, claims administration, calculation of LIS reimbursement, and True Out-of-Pocket (TrOOP administration).

    - Pharmacy benefits management (PBM) administration. All of the costs for performing call center, claims, formulary management, network development, rebate management functions at the plan, or through a subcontractor must be reported in the BPT as direct administration.
    - Crossover Fees. (These are the fees paid to obtain information from other payers in order to calculate TrOOP expenses).
    - Medicare User Fees.
    - Uncollected enrollee premium.
    - Medication Therapy Management Program expenses.

- Disease management functions (such as patient education and disease monitoring are considered to be direct administration).
- Over the Counter (OTC) drug utilization. To the extent that OTCs are permitted to be covered, they must be reported as a component of direct administration, and not as a Part D covered drug or as supplemental coverage.

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

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

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 must be excluded from non-benefit expenses. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid.

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

- Expenditures for tangible assets must be capitalized and amortized according to relevant GAAP principles, e.g., a new computer system purchased to support Part D in 2005.

- Expenditures for non-tangible assets, e.g., salaries and benefits, must be reported consistent with the organization's internal accounting practices and the reporting of similar expenditures in other lines of business.

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 bid pricing tools.

Lines 1 through 5, Column e – Base Period

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

Lines 1 through 4, Column f – Trend

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

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

The value is automatically calculated using columns e and f.

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

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

Lines 1 through 4, Column i – Credibility

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

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

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

Section VI – Development of Manual Rate

Describe the source and year of the information used as the manual rate, as well as any other relevant information, such as benefit design, group size, group characteristics, utilization trends, pricing basis, formulary changes, induction, and risk assumptions.

Worksheet 3 - Contract Period Projection for Defined Standard Coverage

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

Section I - General Information

This section automatically populates from entries on Worksheet 1.

Section II - Projection Data

Line 1 – Projected Member Months

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

Line 2 - Projected Average Risk Score

Enter the projected Rx risk score for the enrollees expected in the contract period. This value must be consistent with the base period risk score (if any) and with the expectation for the change in risk score from Worksheet 2.

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

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

Section III – Part D Covered Drug claims

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

Lines 1through 5, Column d - Number of Members

Enter the number of members who are expected to have allowed Part D Rx expenses falling in the range applicable to the line. For example, when modeling 6,500 members with allowed expenses falling in the range between $265 and $2,400, enter 6,500 on line 3, column d. For purposes of lines 1through 5, do not include estimates for any claims for which Part D is secondary coverage.

Lines 1through 5, Column e - Member Months

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

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

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

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

The average allowed PMPM is calculated automatically.

Lines 2 through 5, Column i - Cost Sharing

For each line, enter the total amount of cost sharing that would apply to the individuals identified in the line under the assumption that the benefits are those of Part D defined standard coverage with no low-income subsidy and no supplemental coverage from any source. The member liability in the gap, before TrOOP is satisfied, is considered cost sharing for this purpose. The cost sharing amounts should be consistent with the total allowed dollars in column g.

Lines 4 through 5, Column j - GAP PMPM

For each line, enter the PMPM amount corresponding to amounts between the initial coverage limit and the catastrophic limit for the individuals identified in column d. For 2006, this amount would correspond to allowed amounts between $2,400 and $5,451.25 of total drug spending.

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

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

Line 5, Column m - Federal Reinsurance PMPM

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

Lines 1through 5, Column n - Plan Liability

The plan liability PMPM is calculated automatically.

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

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

Line 6, all Columns - Subtotal

Each column is calculated automatically.

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

Although rebates are not directly allocable to individual claims, the method used to allocate rebates to the plan must be reasonable and similar to the way in which the rebates are

generated. For the purpose of this worksheet, rebates must include any price concession recognized after the point of sale.

Enter, as a positive dollar amount in column g and as a positive PMPM in column h, the total projected rebates generated in the contract period. This amount is allocated to columns m and n based on the relative amount of reinsurance compared to all allowable costs.

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

As positive amounts in columns h and m, enter the estimated PMPM reduction due to the presence of other Rx insurance. Column n is calculated automatically.

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

Enter in columns h and m the estimated PMPM liability of the plan where Part D coverage is secondary. Column n is calculated automatically.

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

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

Line 12, Columns g through o - Total

The values are automatically calculated based on the previous lines.

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

Lines 1 through 5

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

Line 6

Enter the value for the plan's expected total Gain/ (Loss). Consistent with statutory intent, the gain/loss margin must reflect the revenue requirements of benefits provided under the plan. CMS' interpretation of this requirement is that the gain/loss margin must be developed using an accepted actuarial technique, such as a Return on Investment or Return or Equity approach.

One component of CMS' review will be assessment of the reasonableness of the gain/loss margin relative to other 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 actuarial support. 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.

Section V – Defined Standard Coverage Bid Development

The values for Section V are automatically calculated by the BPT from entries on worksheet 3.

Worksheet 4 - Standard Coverage with Actuarially Equivalent Cost Sharing

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

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

- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for defined standard coverage.

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

Considerations for Actuarial Equivalent Coverage

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

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

Section I – General Information

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

Section II – Projection Data

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

Section III – Development of Bid for Defined Standard Coverage

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

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

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

These items are calculated automatically.

Lines 4, Columns e and h - Allowed PMPM

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

Lines 15, Columns h and k - Rebates

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

Lines 16 and 17, Column e - Success/Failure of Actuarial Equivalence Tests

If line 8 of column e equals line 9 of column e using the threshold test for equivalence, line 16 of column e will display “Yes”.

If line 8 of column h equals line 9 of column h using the threshold test for equivalence, line 17 of column e will display “Yes”.

If both equivalence tests display “Yes,” the bid for standard coverage with actuarially equivalent cost sharing will be automatically be calculated in Section IV.

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

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

Line 6, LIS

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

Worksheet 5 - Alternative Coverage

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

Considerations for Basic and Enhanced Alternative Plans

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

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

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

Finally, alternative plans may provide for coverage in the payment gap. Since the value of coverage up to the ICL must remain the same relative to defined standard, unless the cost of the additional coverage is offset by savings in catastrophic coverage, in a supplemental premium will result. Additional coverage in the gap can also delay the point at which a beneficiary (i) achieves $3,850 of true out-of-pocket (TrOOP) cost-sharing, and (ii) gets catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, can cause induced utilization, and can also increase the risk profile of the group, although those with extremely high spending will not benefit as much as those with a moderate amount of spending and may not opt for these plans.

Section I – General Information

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

Section II – Projection Data

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

Section III – Development of Bid for Defined Standard Coverage

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

Section IV – Development of Bid Components

Columns d through o – Part D Covered Drugs

These amounts represent Part D covered drugs.

Column q – Non-Part D Covered Drugs

These amounts represent Non-Part D covered drugs.

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

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

Line 6, Column d - Proposed Deductible

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

Line 8, Column f – Value of Proposed Deductible

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

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

Line 12, Column k - Coinsurance Percentage in Gap

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

Line 18, Columns o and q - Alternative Plan Rebates

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

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

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

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

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

Section V – Development of Actuarial Equivalent Test

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

Line 9 - LIS

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

Section VI – Tests for Alternative Coverage

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

Section VII – Development of Supplemental Premium

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

Line 6 - Additional Non-Benefit Expenses

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

Line 7 - Additional Gain/ (Loss)

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

Section VIII – Development of Induced Utilization Adjustment

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

Line 2 - Impact of Alternative Utilization on Standard Benefit

Enter the additional basic Part D costs in the first column if the utilization for alternative coverage was used to price defined standard coverage. This adjustment must reflect the additional costs associated with basic coverage. For the 2006 benefit year, this amount represents 75% of costs between the $265 deductible and the $2,400 initial coverage limit, plus 15% of costs in excess of the basic catastrophic limit or $5,451.25. This adjustment should be calculated only for enhanced alternative plans and the adjustment must be a positive number.

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

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

There are two significant changes to Worksheet 6 in the BPT for contract year 2008. Specialty drugs are broken out and reported separately under type of script, and data is now collected for four levels of allowed spend under "Projections for Equivalence Tests."

Specialty Drugs

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

A separate breakout of specialty drugs on Worksheet 6 is only required when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier is designated a specialty tier, (ii) cost sharing associated with that tier is limited to 25% in the initial coverage range, and (iii) only Part D drugs with plan negotiated prices greater than $500 per month may be placed in the tier.

When a designated specialty tier is used, all drugs in the designated specialty tier must be reported by place of service, on lines 4 and 8, 13 and 17, 22 and 26, 31 and 35 in Section II of Worksheet 6. When a designated specialty tier is used, the drugs in the specialty tier are not sorted by preferred brand, non-preferred brand or generic status, and are not reported as a component of the brand and generic drugs in the non-specialty tiers.

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

Data Required for Levels of Allowed Spend

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

Lines 1 through 8 collect data on all allowed costs for the "Population Not Exceeding $2400 with Standard Coverage." All utilization for the population with total allowed costs that do not exceed $2400 must be reported in this section.

Lines 10 through 17 collect data on all allowed costs for the "Population Exceeding $2400 with Standard Coverage." All of the utilization for the population with total allowed costs that exceed $2400 must be reported in this section.

Lines 19 through 26 collect data on all allowed costs up to $2400 for the "Population Exceeding $2400 with Standard Coverage." All of the utilization for allowed costs allocated up to $2400, for the population with allowed costs that exceed $2400 is reported in this is section.

Lines 28 through 35 collect data on all allowed costs over the catastrophic coverage limit for the "Population Exceeding $2400 with Standard Coverage." All of the utilization for allowed costs allocated over catastrophic coverage, for the population with allowed costs that exceed $2400 is reported in this is section.

Considerations

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

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

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

Data in Section II of Worksheet 6 are collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit and is not expected to model all of the aspects of plan design. Lines 1 through 18 summarize all of the claims expected to be utilized, with lines 1 through 9 capturing the claims for individuals with less than $2,400 in annual drug claims and lines 10 through 18 capturing the claims for individuals with $2,400 or more in annual drug claims. Lines 19 through 27 captures the claims or amounts allocated up to ICL for individuals with $2400 or more in allowed costs. Lines 28 through 36 captures the claims for individuals expected to reach catastrophic coverage, is $5451.25 or more in annual drug claims for contract year 2007. Note that amounts summarized in lines 19 through 27, and 28 through 36 are subsets of the amounts summarized in lines 10 through 18; amounts in the gap are intentionally excluded.

Plans should follow instructions carefully in developing cost sharing values for column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the cost sharing elements for the proposed defined standard benefit. For lines 1 through8, and lines 19 through 27, column h captures the cost sharing for the claims summarized in columns f and g using the cost sharing applicable between the deductible and the initial coverage limit for all claims allocated up to the ICL. This means that column h develops cost

sharing without the impact of the deductible, the gap in coverage and catastrophic coverage. For the purpose of this worksheet, plans should ignore the impact of low-income cost sharing subsidy. Since column h summarizes the defined standard benefit, all of the claims reflect cost sharing of 25%.

The worksheet must be completed for column h for lines 28 through 36 using cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this amount is greater of 5% or $2 for generic/ $5 for brand name drugs.

Plans submitting a bid to provide an actuarially equivalent or alternative benefit are required to report the projected utilization and costs on the proposed benefit in Section II, column i, j, and k. Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making appropriate adjustments in utilization and average script pricing in Worksheet 6. Specifically, the distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. The distributions should be based on the splits as outlined in the defined standard coverage. For example, lines 1 through 9 should reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,400 in annual coverage based on the defined standard coverage. In other words, the amounts summarized in columns i, j and k are based on the same population summarized in columns f, g, and h.

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

Plans should be aware of the situations outlined in the “Special Considerations” section of these instructions for Worksheet 6 implications for plans that offer first dollar generic coverage or for plans that reduce the initial coverage limit.

Section I – General Information

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

Section II – Projections for Equivalence Tests

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

Lines 1 through 8

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

Columns i through k – If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars, and cost sharing for the population identified in line 1, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage. These numbers include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 9

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

Lines 10 through 17

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

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

Line 18

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

Lines 19 through 26

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

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

Line 27

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

Lines 28 through 35.

Columns f through h – Enter the projected scripts, allowed dollars, and cost sharing for defined standard coverage, with cost sharing calculated using the

copay/coinsurance structure that applies in defined standard coverage once the catastrophic threshold has been reached.

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

Line 36.

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

Line 37

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

Worksheet 7 – Summary of Key Bid Elements

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

SECTION II – 2007 Defined Standard Benefit Parameters

Line 1 – Deductible

This value is the deductible for a defined standard package.

Line 2 - Initial Coverage Limit

This value is the initial coverage limit (ICL) for the benefit priced in this bid.

Line 3 - Out-of-pocket Limit

This value is the out-of-pocket limit (OOP) for the benefit priced in this bid.

SECTION III – Summary of Key Bid Elements

Line 1 – Standardized Part D Bid

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

Line 2 - National Average Monthly Bid Amount

This field requires a manual input at the time of bid submission. Enter the estimated National Average Monthly Bid Amount that the plan is anticipating. The final value for the National Average Bid Amount for contract year 2007 will be released some time after this value is entered, and the bid is submitted.

Line 3 – Base Beneficiary Premium

This field requires a manual input at the time of bid submission. Enter the estimated Base Beneficiary Premium amount that the plan is anticipating. Together with the National Average Monthly Bid Amount and the Basic Part D A/B Rebate allocation reported on the MA Bid Pricing Tool for MA plans, these amounts will determine the plan's basic Part D Target Premium that will be used during the rebate reallocation period.

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

The values on lines 4 and Line 5 are the plan's expected base beneficiary premium, calculated from the plan's manual inputs on lines 1, 2, and 3 of this section. Line 4 reflects the value of the Basic Part D premium before application of the rounding rule, and line 5 reflects the value after the rounding rule selected on Line 8 of this section has been applied. These amounts will be updated to reflect the actual National Average Monthly Bid Amount and Base Beneficiary Premium after these amounts are published in early August.

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

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

Line 8 - Prospective Federal Reinsurance (non-standardized)

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

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

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

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

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

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

Line 11 - Rounding Rule

This field requires a manual input. MA-PD plans are required to round to the nearest $0.10; PD plans are required to round to either the nearest $0.10 or nearest $0.50 and must select the preferred method for rounding the Part D premium from the drop-down menu. The default will be $0.10 in all cases where a selection is not made.

Section IV - Part D Bid Pricing Tool Contacts

Plans are required to identify two persons who are readily available and are authorized to discuss the development of the bid. Provide the requested contact information (name, phone, and e-mail) for the Plan Bid Contact and Part D Certifying Actuary.

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany *every* bid submitted to HPMS. A qualified actuary who is a *member of the American Academy of Actuaries* (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater 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 and Financial Projections for Health Plans. Particular focus is placed on the sections dealing with the Recognition of Benefit Plan Provisions (5.2), Consistency of Business Plan and Assumptions (5.3), Reasonableness of Assumptions (5.4), and Use of Past Experience to Project Future Results (5.5).
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans.
- ASOP No. 23, Data Quality. Particular focus is placed on Section 5, Analysis of Issues and Recommended Practices, and Section 6, Communications and Disclosures.
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage.
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking.

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

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.

Toward the end of the CY2007 bid review process (likely in mid-August), each plan will be required to submit the final actuarial certification. Again, no material changes to the certification language will be considered. The certification must be updated for the following:

- Date of the signed certification.
- Date BPT prepared (see worksheet 6 of MA BPT, worksheet 7 of PD BPT).
- HPMS version # of accompanying PBP (or HPMS *PBP* upload date).

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

The identifying information above (date of certification, date BPT prepared, and PBP version #) 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.

While the resubmission of a *final* actuarial certification is a new requirement, plans are no 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 another 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 prefers that the certification uploaded to HPMS contains an electronic signature. However, if the electronic certification uploaded to HPMS does not contain the signature, mail the paper copy of the signed certification (postmarked by Monday June 5, 2006) to:

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

- Name of the certifying actuary, title, employing firm, contact information, credentials, qualifications, and relationship of the actuary to the organization submitting the 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 BPT was prepared (must match the date entered on BPT Worksheet 6 for MA and Worksheet 7 for PD).
- The MA (and PD) PBP version #, assigned by HPMS, that identifies the benefits priced in the BPT. If version # is unavailable, the certification must include the PBP upload date (i.e., the date that the latest PBP was uploaded to HPMS). The certifying actuary should be made aware of any changes to the PBP after the initial bid submission.
- 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). Attestation that the data and assumptions are in accordance with the organization's business plan.
- Attestation that the bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries and that the bid complies with the appropriate ASOPs.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this reliance must be disclosed, and the actuary must obtain a letter of reliance from that person. The reliance letter does not need to be included with the initial bid submission but must be available upon request and for an audit.
- 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)_____ 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	Bid ID (Contract - Plan - Segment)	Certification applies to MA bid?	MA BPT Date Prepared	MA PBP HPMS version #	Certification applies to PD bid?	PD BPT Date Prepared	PDP PBP HPMS version #
Health One	H9999-001-00	Y	05/15/2006	1	Y	05/20/2006	1
Health One	H9999-002-00	Y	05/04/2006	1	N		
Health One	H9999-003-00	Y	05/10/2006	1	Y	6/1/2006	1

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) and 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 found the data and assumptions upon which I relied to be reasonable. I have uploaded supporting documentation that contains further information describing the nature of these data and assumptions. A copy of each individual's certification is available upon request.

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

Organizations must provide CMS with supporting material in addition to the bid form and actuarial certification. 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.

Before submitting the Rx bid forms, plans must complete a series of calculations and enter the results on 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. Organizations will not be required to send paper copies of supporting documentation, except as noted in Appendix A for signed copies of the actuarial certifications.

CMS requires that the following supporting documentation be included with the Rx bid submission:

- Signed actuarial certification.
- Support for the manual rate development.

The following additional items are not required to be included with the initial submission, but must be available upon request as part of the bid review process, and will be reviewed at audit:

- Reconciliation of base period experience with company financial data.
- Support for projection assumptions.
- Support for non-benefit expense assumptions.
- Support for risk factors.

Organizations often upload numerous documents that contain supporting documentation. It would expedite the bid review process if organizations were to 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.

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

Appendix C – Employer/Union-only Group Requirements

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

- Provide coverage at least as good as Medicare's Part D Defined Standard benefit and receive a tax-free retiree subsidy of 28% of a retiree's drug costs between $265 and $5,350.
- Purchase customized benefits from a PDP or MA-PD pursuant to CMS waivers, or
- Contract directly with CMS to become a PDP and provide customized benefits pursuant to CMS waivers.

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

For CY2006, CMS issued guidance waiving or modifying many of the requirements for these entities. CMS waiver guidance is located at http://cms.hhs.gov/EmpGrpWaivers. All of the standard Part D bidding guidelines applies with the exception of those specifically waived.

The following summarizes the key requirements for Part D employer/union-only group bidding:

- All Part D bids are based on Defined Standard coverage with no supplemental benefits.
- For Part D sponsors offering calendar and non-calendar year plans, separate bids must be submitted.
- The service area can be defined as "national" to enable employers and unions to cover all retirees nationwide under the same plan.
- Each employer/union-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan in CY2007.
- There is no requirement to charge the filed PD basic premium to any employer/union-group only.

The CY2007 Call Letter may contain additional guidance regarding employer/union-only group bidding.

Appendix D - Bid Pricing Tool Technical Instructions after Download from HPMS

Installation Requirements Summary

There are five critical elements that must be configured for the BPT to work correctly after download from HPMS. You must:

- Create a C:\Program Files\BPT2007 folder on your workstation

Note: If you are using Windows XP Home Edition you may need to unhide your C:\Program Files directory.

- Place the BPT Add-In (BPT.xla) file in C:\Program Files\BPT2007 folder
- Always overwrite the existing BPT Add-In file saved on your workstation with the newer one. (Do not move/copy the add-in to another location on your workstation.)
- Set your Macro Security Settings to Medium (or Low)
- Enable Macros when you open the BPT workbook

BPT Add-In

The 2007 BPT (BPT) is composed of two files:

- BPT workbook (.xls file)
- BPT Add-In (.xla file)

The BPT workbook file contains the editable BPT worksheets. The BPT add-in contains the code to support the BPT workbook functionality. The add-in must be installed in the correct location on your computer in order to update the BPT workbooks. The add-in is automatically downloaded with the Plan Benefit Package (PBP) or can be obtained as a separate download from the HPMS Bid Submission Module. The initial PBP installation will save the BPT workbooks to the C:\Program Files\PBP2007 folder. The add-in file will be saved in the C:\Program Files\BPT2007 folder. If you download the add-in file directly from HPMS, you must create the C:\Program Files\BPT2007 folder and save the add-in to the BPT2007 folder.

If you do not save the add-in in the designated folder, you will receive a message stating that the .xla file (add-in file) cannot be found. The BPT will open in a read only mode. You will not be able to save any changes you make to the BPT if the add-in is not saved in the correct folder.

In certain situations, the Centers for Medicare & Medicaid Services may deploy a new version of the add-in file (e.g. change in a formula, change in a reference value). The new version will be made available to the user community through the HPMS system. You will receive an HPMS generated email informing you that a new add-in is available and will be instructed to download it from the HPMS. It is imperative that you overwrite the existing add-in with the more current add-in in the C:\Program Files\BPT2007 folder. If you save multiple versions of the add-in to the BPT2007 folder or elsewhere on you computer, you cannot be assured of using the latest version of the add-in file due to a Microsoft limitation.

Note: If you receive the add-in file via email and it is saved to your temporary directory as part of the email download process, you must delete it.

When you open your BPT for the first time after downloading the new add-in file, you will receive a message stating that the BPT is out of date and is being updated. You must click OK to start the update process. As part of this process, a back up version of your previous BPT will be saved to a C:\Program Files\BPT2007\Update Version (version number) folder.

The add-in will not interfere with any non-BPT files.

Note: If you want to open multiple BPTs at the same time, you will need to open them from within the same Excel window using either the File, Open menu or by dragging a file from the explorer window into your Excel window. If you open a new Excel window for a second BPT, the file will open in read-only mode. (Clicking on a file from Windows Explorer opens a new Excel window).

Enable Macros

The BPT workbooks use macros to enable validation and other BPT functionality.

We recommend that you set your Macro Security Settings to 'Medium'. You can do this by selecting Tools → Macro→ Security from your Excel menu. You will not be able to open the BPT if your macro security settings are set to High or Very High.

If your Macro Security settings are set to Medium, you will be prompted to enable or disable macros when you open the workbook. You must enable macros to use the BPT. If you disable macros, the workbook will display a screen explaining that you must enable macros to use the BPT. You will have to close and then reopen the workbook to enable macros.

Data Pre-population

When you open a BPT workbook that was downloaded with the Plan Benefit Package (PBP) software, a subset of data in Section I will be populated for you. In some cases, you may have to enter or change the Section I data. The Section I yellow highlighted cells on the first worksheet of each BPT workbook are unprotected to allow you to enter or change values.

If you download a blank BPT, you will have to enter the data into Section I yourself.

Data Entry

All data entry fields in which you may enter values are highlighted in yellow. This includes the cells for pre-populated data in Section I of each workbook's first worksheet. When the majority of the data to be entered in a BPT workbook is the same (such as for plan segments), you can make a copy of your un-finalized BPT workbook and change the necessary heading data cells on worksheet 1 to reduce the need to re-enter duplicate data.

When you download the BPT separately from the PBP, the BPT data is not pre-populated. When we pre-populate the data for you, we adjust some of the formatting to display leading zeros on certain entries, e.g. Plan ID. If you are manually inputting data in the following user entered fields, we recommend that you add the apostrophe (') and leading zeros as part of the value:

- Plan ID (Worksheet 1, Section 1, General Information)
- Segment ID (Worksheet 1, Section 1, General Information)
- Region ID (Worksheet 1, Section 1, General Information)
- County Code (MA Worksheet 5)

Examples:

Region 5 → Input the value '05. 05 will be displayed in the BPT.
Plan ID 30 → Input the value '030. 030 will be displayed in the BPT.

Linking

You will be able to link information from other workbooks into the BPT. You will need to follow specific instructions to link information into the BPT for the following cells:

- Plan ID (Worksheet 1, Section 1, General Information)
- Segment ID (Worksheet 1, Section 1, General Information)
- Region ID (Worksheet 1, Section 1, General Information)
- County Code (MA Worksheet 5)

If linking data into these cells, you will need to format the cells in your non-BPT workbook as general and place an apostrophe and leading zeroes prior to the actual value. The apostrophe is an Excel formatting character and will not be displayed in the BPT.

Examples:

Region 5 → Your input workbook must have the value '05. 05 will be displayed in the BPT.
Plan ID 30 → Your input workbook must have the value '030. 030 will be displayed in the BPT.

Errors

Some of the user-entered data is validated for accuracy. For example, some percentage fields cannot have values greater than 100%. Errors are indicated by red circles around the cell(s). In order to check for errors, you must click on the Circle Invalid Data button  on the BPT toolbar. Clicking the button will circle all cells that fail the validations. The Circle Invalid Data function will also execute when opening and saving (including the finalized save) the BPT.

If your cursor is on a cell with a red circle, a small message box will appear and display the cell location and validation test for that cell. You may move this input message box to any section of your screen by clicking and dragging the box. The error message will remain open until you select another cell.
Changes Not Allowed
You may not make changes to the structure of the BPT worksheets. Each data item must be in its pre-defined cell location for processing by the HPMS system.

Undo

The 2007 BPT will support the Excel undo functionality with certain exceptions. Modifying any of the cells listed below will cause the actions/states stored in your undo history* to be deleted. This means that after entering, changing, or deleting a value in any of the following cells, you will not be able to undo your actions.

- Plan Type
- Contract Number
- MA\PD Region
- PD Benefit Type
- County Codes
- Use of ISAR
  - Any other cell composed of a drop down box

- Any cell that has a validation error removed due to a correction in the user entered data

A new undo history will begin to compile after each of these cells are modified to pass the validation.

* The "undo history" is a built-in Excel feature that keeps a record of changes made to a workbook. This allows a user to step backwards through a list of applied changes. Unfortunately, other built-in Excel functions, including some of those used by the BPT, erase this information automatically due to the large amounts of memory required to maintain the undo history list.

Saving

There are two save processes available within the BPT. A non-finalized save can be invoked by clicking on the Excel Save icon on the menu bar or by selecting File → Save from the Excel menu. This save process will save any changes you have made to the BPT workbook.

If you are ready to complete your BPT, you will invoke the Finalize Save functionality. You may do so by clicking on the Finalize BPT icon 

on the toolbar or by selecting File → Finalize BPT from the Excel menu.

If you are trying to finalize an MA workbook, a subset of validations will be run. If any of these validations are not met, a message will display stating that you are unable to finalize your BPT. You will need to modify the appropriate cells and invoke the finalization process again. The validations that will prevent you from finalizing your MA BPT are listed below:

- All rebates must be allocated
- Part B and D rebates must be rounded to one decimal point
- There are no negative premiums
- Allocated rebates do not exceed the maximum value
- There are no negative rebate allocations
- For 800 Series plans, Part D rebates must equal 0

As part of the finalize process: 1. The working file will be saved; and, 2. A finalized file and a back up file will be created using the following naming convention:

- Back-up File: ContractNo+PlanID+SegmentID+WorkbookType+"Backup"-YYYY-MM-DD-HHmm.xls

  Example: H1111001001MABackup-2006-05-20-1000.xls

- Finalized File: ContractNo+PlanID+SegmentID+WorkbookType.xls

  Example: H1111001001MA.xls

The finalized file and the back up file are read only files. If you need to make additional changes prior to your submission, you should modify your working file. Once complete, you

can finalize the BPT again. Your previous finalized file will be overwritten. A new back up file will be created. Backup files will not be overwritten. To modify a backup file, rename the file and eliminate the word "backup" from the filename.

You must finalize your workbooks before packaging them with the Plan Benefit Package data for upload to HPMS.

When you finalize a Part D workbook, blank worksheets that were not applicable to your bid will be added to the workbook, e.g. a blank Actuarially Equivalent worksheet will be added when you're submitting a Defined Standard Coverage Bid. Any data that may have been entered on these "extra" worksheets will be deleted during the finalization process.
File Naming for Bid Submission

Finalize BPT workbooks are saved with the correct file name (ContractNo+PlanID+SegmentID+WorkbookType.xls) required for a successful bid upload. In order for the Plan Benefit Package to prepare your bid submission file, your BPT workbooks must be finalized and named using this format.

Save/Update Batch Application

A batch application will be available to users to update the BPT add-in file and to finalize BPTs. The batch file was created to reduce the process time for users that maintain a large volume of BPTs. The batch file opens a workbook, runs the update or finalize function within the BPT, and then closes the workbook. The estimated time for the batch file process can vary greatly depending on the number of workbooks in the batch, the number of county codes in the individual workbooks and the user's workstation processing power. You may want to run a small batch of five to ten workbooks to estimate how it will perform in your individual setting. The batch file is available for download from the HPMS Bid Submission module.

If a new version of the add-in has been deployed to HPMS, you will be able to run the batch application to update all of your BPT workbook files to use the latest add-in. You can do so by opening the batch application and selecting the 'Update BPT' option. Browse through your folder structure and highlight the BPT (with file extension .xls) files to be updated by the new version of the add-in. Upon clicking Update, the batch will begin to run. The batch will disable all buttons that may disrupt the batch process. On the screen you will be able to track the status of the updates. A success or failure message is displayed for each of the BPTs. If any updates fail, the associated error messages will be displayed.

If you are trying to finalize multiple BPTs through the batch application, you must select the Finalize BPT option. You will browse through your folder structure and highlight the BPT (with file extension .xls) files to be finalized. Upon clicking Finalize, the batch will begin to run. The batch process will disable all buttons that may disrupt the batch process. On the screen you will be able to track the status of the finalization process. The batch tool will display status messages for each workbook selected, either "Contract, Plan, Segment: The BPT has been finalized" for successes or "Contract, Plan, Segment: The BPT cannot be finalized" for failures.

The batch application will neither update the add-in nor finalize a previously finalized BPT, a backup BPT, or a non-BPT file. The process will skip these files if they are selected and log or display a message.

You must close all BPTs before running either of the batch processes. Failing to do so will prevent you from running the batch process.

Contacting HPMS

If you have any other questions concerning the use of the BPT workbooks, please contact the HPMS Help Desk at 1-800-220-2028 or via email at hpms@cms.hhs.gov.

Appendix E – Red-Circle Validation Edits in the Prescription Drug Plan Bid Form

The purpose of the "red-circle" validation rules in the BPT is:

- to highlight *some* of the fields that require data entry by the user, and
- to highlight *some* user-entered data that may be invalid.

Following is a description of all validation rules in the PD BPT.

Worksheet 1

Section I

D5	Contract Number cannot be blank and text length must be 5.
D6	Plan ID Number cannot be blank and text length must be 3.
D7	Segment ID Number cannot be blank and text length must be between 1 and 3.
F6	The Organization Name cannot be blank and may be up to 200 characters.
F7	The SNP Indicator must be "Y" or "N".
I5	The Plan Name cannot be blank and the text length must be between 1 and 200.
I6	The Plan Type cannot be blank must be between 1 and 40.
I7	If the Plan Type is Employer Sponsored PDP, Medicare Prescription Drug Plan or Fallback than the Enrollee Type must be blank, otherwise the Enrollee Type must be 'A/B' or 'Part B Only'
N~~M~~5	The PD Region cannot be blank or 'N/A' if the Plan Type is RPPO, otherwise it must be a number between 01 and 39 or 'Multiple', 'National', 'N/A'.
N~~M~~6	The PD Benefit Type must be DS, AE, BA or EA.
N~~M~~7	The Payment Demo Type must be NA, Fixed Cap, Flex Cap, or MA Rebate.

Section II

D12	Time Period Definition - Incurred from date must be earlier than today's date.
D13	Time Period Definition - Incurred to date must be between Incurred from date and today's date.
D14	Time Period Definition - Paid through date cannot be greater than today's date.
I13	The Credibility must be 'F' for full credibility, 'P' for partial credibility, or 'N' for none.

Section III

G37	The Total Amount of Rebates received by the Plan should be entered. The PMPM value is calculated in Column I.
G38	The Total Value of Part D as Secondary should be entered. The PMPM value is calculated in Column I.
N~~M~~33	The Net Plan Responsibility per Member Subtotal should be greater than zero.

Section IV

E48-E51	All Components of Non-Benefit expenses for Basic must be greater than or equal to zero.
F48-F51	All Components of Non-Benefit expenses for Supplemental must be greater than or equal to zero.

Section V

E58-E61	Each component of Premium Revenue for Basic must be greater than or equal to zero.
F60	Member Premium for Supplemental must be greater than or equal to zero.
E62	The Total of Member Premium for Basic must be greater than or equal to zero.

F62 The Total of Member Premium for Supplemental must be greater than or equal to zero if PD Benefit Type is equal to “EA”.
G62 The Total of Member Premium must be greater than or equal to zero.

Worksheet 2

Section II
G32 The Total Allowed PMPM should be within +/- $1 of the Subtotal of the Average Allowed Amount PMPM on Drug Plan Financials Worksheet (H33).

Section III
K56 The Total Projected Allowed PMPM must be greater than zero if the Total Credibility is greater than zero %.

Section IV
N56 The Total Manual Rate PMPM must be greater than zero if the Total Credibility is less than 100%.

Worksheet 3

Section II
H11 Projected Average Risk Score for the contract year must be between 0.3 and 10.0.
L11 The projected LIS member months for the contract year must be greater than or equal to zero.

Section III
F25 The Subtotal of the Number of Scripts should be within +/- 2 from the sum of cells F19 and F31 on Script Projections Worksheet.
G25 The Subtotal for Projected Allowed should be within +/- $5 from the sum of cells G19 and G31 on Script Projections Worksheet.
G27 The Projected Allowed for Minus Rebates must be greater than or equal to 0.
E20-E24 Member Months should be less than or equal to the Projected Members times 12.
H25 The Subtotal for the Average Amount of Allowed PMPM should be within +/- $1 of the Total Blended Allowed Cost on Projection of Allowed-Admin Worksheet.
E31 The Allowed Member Months for the Projected % OON Included should be between 0% and 100%

Section IV
D44 Enter the expected Gain/(Loss).

Worksheet 4

Section IV
E34 The Standard with Actuarially Equivalent Cost Share Allowed PMPM for members below the Initial Limit must be greater than zero if PD Benefit Type is "AE".
H34 The Standard with Actuarially Equivalent Cost Share Allowed PMPM for members above the Catastrophic Limit must be greater than zero if PD Benefit Type is "AE".

K54	The Standard with Actuarially Equivalent Cost Share Rebates Including Reinsurance must be greater than zero if PD Benefit Type is "AE".
E59-E60	The Actuarial Equivalence Tests should equal "Yes" if the PD Benefit Type is "AE".

Section V

K19	The Total Basic Bid must equal the sum of cells K16 through K18.
K21	The LIS for Bid with Actuarially Equivalent Cost Sharing must be greater than zero if the Federal LIS PMPM Total is greater than zero and PD Benefit Type is AE.

Worksheet 5

Section II

K11	The risk score must be consistent with the risk score from Standard Coverage Worksheet.

Section IV

D39	Proposed Deductible for the Alternate Coverage should be greater than or equal to zero and less than or equal to the Deductible on the Summary Worksheet.
F41	Value of the Proposed Deductible should be greater than zero if cell D39 is greater than zero.
O36	Standard Total Allowed PMPM should be equal to the Average Amount Allowed PMPM Subtotal on Standard Coverage Worksheet, +/- $0.02.
O37	Alternative Total Allowed PMPM should equal the sum of the Total Allowed Dollars divided by the Projected Member Months, +/- $0.02.
K37	Allowed PMPM Amounts in Gap for Alternative Coverage must be greater than zero.
K47	Coinsurance % for Alternative Coverage Amounts in Gap must be less than or equal to 100%.
M37	The Allowed PMPM Amounts above Catastrophic Threshold for Alternative Coverage must be greater than zero.
M59	Federal Reinsurance - Other Insurance Alternative Amounts above Catastrophic Threshold must equal to Other Insurance Standard Amounts above Catastrophic Threshold if Payment Demo Type is "Flex Cap" or "Fixed Cap".
M62	The Plus Part D as Secondary - Alternative Amounts above Catastrophic Threshold must be equal to Plus Part D as Secondary - Standard Amounts above Catastrophic Threshold if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O56	The Alternative Minus Rebates for all members must be greater than or equal to zero.
O59	The Alternative Minus Other Insurance for All Members must be equal to Standard Minus Other Insurance for All Members if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O62	The Alternate Part D as Secondary Total PMPM for All Members must be equal to Standard Part D as Secondary Total PMPM for All Members if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O64	The Standard Net Cost Benefit for the Total PMPM should equal the Total Plan Liability PMPM on Standard Coverage Worksheet.

Section V

O24 The LIS at plan risk for Alternative Coverage must be greater than zero if the Total of Federal LIS PMPM in Standard Coverage Worksheet (O33) is greater than zero.

Section VI

G68 Total Coverage Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G69 Unsubsidized Value Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G70 Average Cost at Initial Coverage Limit Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G71 Deductible Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G72 Average Catastrophic cost sharing Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

Section VII

O76 Development of Supplemental Premium Gain/Loss should be zero if PD Benefit Type is "BA" or greater than zero if it is "EA".

Section VIII

F77 Impact of Alternative Utilization on Standard Coverage at plan risk must be blank or greater than or equal to zero.

Worksheet 6

Section II

F19 Number of Scripts on Script Projection Worksheet must be within +/- 2 scripts of the Standard Coverage Worksheet (F21:F22).

G19 Total Allowed Dollars must be within +/- $5 of the Standard Coverage Worksheet (G21:G22).

I19~~28~~ Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J19~~28~~ Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

K19 Total Cost Sharing Dollars should be greater than or equal to zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan Type is not DS.

F31 Number of Scripts on Script Projection Worksheet must be within +/- 2 scripts of the Standard Coverage Worksheet (F23:F24).

G31 Total Allowed Dollars must be within +/- $5 of the Standard Coverage Worksheet (G23:G24).

I31 Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J31 Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

I42 Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J42 Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

K42 The Total Cost Sharing Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

H34-H42 The Cost Sharing Dollars should be equal to 25% of the Allowed Dollars and it should be greater than zero if the associated Population/Member Months cells are greater than zero.

H45-H52 The Cost Sharing Dollars should be equal to 25% of the Allowed Dollars and it should be greater than zero if the associated Population/Member Months cells are greater than zero.

F53 Number of Scripts on Script Projection Worksheet must be within +/- 2 scripts of the Standard Coverage Worksheet (F24).

G53 Total Allowed Dollars must be within +/- $5 of the Standard Coverage Worksheet (G24).

I53 The Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.

J53 The Total Allowed Dollars should be greater than zero if the Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.

K53 The Total Cost Sharing Dollars should be greater than or equal to zero if the Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.

I56 Non-Part D Covered Number of Scripts for Actuarially Equivalent or Alternative Coverage must be greater than or equal to zero if the PD Benefit Plan is not DS.

J56 Non-Part D Covered Allowed Amount for Actuarially Equivalent or Alternative Coverage must greater than or equal to zero if PD Benefit Plan is not DS.

K56 The Total Cost Sharing Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.

Worksheet 7

Section III

F16 Summary of Key Bid Element for National Average Monthly Bid Amount must be greater than zero.

F17 The Summary of Key Bid Elements for Base Beneficiary Premium must be greater than zero and less than the Summary of Key Bid Element for National Average Monthly Bid Amount.

F32 $0.10 or $0.50 must be selected. If neither is selected, the default is $0.10.

Section IV

C36 Plan Bid Contact Name cannot be blank.

C37 Plan Bid Contact Phone cannot be blank.

C38 Plan Bid Contact Email cannot be blank.

C40 Part D Certifying Actuary Name cannot be blank.

C41 Part D Certifying Actuary Phone cannot be blank.

C42 Part D Certifying Actuary Email cannot be blank.

C43 Date Prepared cannot be blank.

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Credibility. The determination of the appropriateness of a plans experience must include the evaluation of whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience must be representative of the benefits that will be offered in the contract period. For example, a plan that will be offering defined standard Part D coverage must have experience for a benefit with a gap in benefits and catastrophic coverage for a population similar to the population they expect to be covering. Most plans will not have appropriate base period experience to be used for contract years 2006 or 2007. However, a plan that has appropriate base period data needs to evaluate the credibility of this data. Although we have not yet established credibility guidelines, we expect prescription drug experience to have a higher level of credibility than medical coverage for a group of similar size. We expect that an appropriate use of actuarial judgment will be exercised in determining the credibility factor for a plan's base period experience.

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

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

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

generics and preferred multiple source drugs and $5 for all other drugs or 5 percent of the price.

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

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

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

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

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

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

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

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

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

Non-full benefit dual eligible beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy assistance (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs

(1) Premium subsidy amount as defined in §423.780(b)
*The percentage shown in the table is the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region.

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

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

MA. Medicare Advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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