OMB Approved # 0938-0944

# INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOL FOR CONTRACT YEAR 2007

May 1, 2006

CMS-10142 (03/2009)

## Table of Contents

# Introduction

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

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

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

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

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

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

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

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

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

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

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

In addition to these instructions, information regarding CY2007 bidding may be found at the following resources:

- The **CY2007 Final MA/MA-PD Call Letter** contains information and guidance pertaining to CY2007 bidding, and may be found at http://www.cms.hhs.gov/HealthPlansGenInfo/08_LettersandAnnouncements.asp#TopOfPage .

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

- CMS Office of the Actuary will host weekly **actuarial technical user group calls** regarding actuarial aspects of the CY2007 bidding process. The conference calls will include live Question & Answer sessions for participants to speak with CMS actuaries. Call information:

    - Every Thursday, April 20 - June 1, 2006
    - 11:00AM - 12:30PM EDT
    - Dial-In Number: 1-800-857-0086
    - Password: Benchmark
    - Call Leader: Richard Coyle

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

    - Appendices I and J of these instructions.

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

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

# General Overview

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

The MA bid form is organized as outlined below:

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

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

In addition, each organization must complete the Two-Year Look-Back form, unless it did not have any Medicare experience in 2005 (i.e., if the organization did not file *any* CY2005 ACRs). All bids uploaded to CMS must be accompanied by an actuarial certification.

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

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

Some of the material changes in the CY2007 bid form and supporting documents (as compared to the CY2006 BPT) are highlighted below. These changes were a result of feedback received from industry and were made in an effort to reduce reporting burden and increase the usability/functionality of the BPT.

- Worksheets 3A and 3B have been consolidated onto one worksheet – Worksheet 3.
- Non-medical expenses and gain/loss margin have been allocated proportionately between Basic (Medicare-Covered) and Mandatory Supplemental on Worksheet 4.
- The reporting of non-medical expenses on Worksheet 4 has been consolidated into fewer categories.
- The reporting of ESRD costs has been revised (see Worksheet 4 and its accompanying instructions).
- County-level enrollment on Worksheet 5 is now reported in terms of *member months*, rather than average monthly members.

- Generally, CY2007 plan payments are based on 100% risk adjusted rates. (In CY2006, plan payments were based on a blend of demographic and risk rates.) Worksheet 5 has been rearranged such that the demographic rates have been moved to the far right of the worksheet, and are used for payment purposes by certain demonstration plans only.
- Part D premiums are now included on the MA BPT (Worksheet 6). The MA BPT summarizes a total plan premium (MA + PD). It is important to note that when the bid forms are initially submitted to CMS in June, this total plan premium is an *estimate,* as the Part D National Average Bid Amount will not have yet been calculated by CMS. The final plan premium will be determined after the Part D National Average Bid Amount is released by CMS.
- Premiums on Worksheets 6 and 7 have been rounded to one decimal, to comply with withhold system requirements. Rebates applied to Part B and Part D premiums must also be rounded to one decimal.
- A final actuarial certification, with updated bid submission identifiers, must be uploaded for all bids toward the end of the bid review process. No material changes to the certification language will be considered after the initial June certification, without prior approval from CMS OACT. Plans are no longer required to resubmit certifications for each resubmission. (See Appendix A).
- Instructional changes are throughout this document, as well as in several new Appendices.

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

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

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

# Worksheet 1 - MA Base Period Experience and Projection Assumptions

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

All information provided on Worksheet 1 must exclude ESRD enrollees.

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

- A reconciliation of base period experience with company financial data.
- Support for projection assumptions.
- Information about "actuarial swapping" or the "actuarial equivalence" category of customization allowable for employer and union groups, as described in Appendix D.

## SECTION I - GENERAL INFORMATION

The fields of Section I have been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, numeric fields, such as Plan ID, Segment ID and Region Number, must be entered as text (i.e., using a preceding apostrophe) including any leading zeros.

**Line 1 – Contract Number**. Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional PPO plan), or E (Employer/Union Direct Contract Private FFS plan) and includes four Arabic numerals (e.g., H9999, R9999, E9999). Include all leading zeros (e.g., H001, H0123).

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

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

**Line 3 – Segment ID**. If the bid is for a service area segment of a local plan, enter the segment ID. This field must be entered as a text input (i.e., must include a preceding apostrophe) and include any leading zeros (e.g., '01).

**Line 4 – Contract Year**. This cell is pre-populated with the calendar year to which the contract applies.

**Line 5 – Organization Name**. Enter the organization's legal entity name. This information must be entered exactly as it appears in the HPMS, which is also displayed in the PBP.

**Line 6 – Plan Name**. Enter the plan name of the plan benefit package that corresponds to the information contained in this bid pricing tool. This information must be entered exactly as it appears in the HPMS, which is also displayed in the PBP.

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

The MA bid form should not be completed for MSA, Cost, and PACE plans. There is a separate CY2007 MSA Bid Pricing Tool.

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

| Type of Plan | Plan Type Code used in BPT |
|---|---|
| **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 |
| **Employer/Union Direct Contract Private Fee-for-Service:** | |
| Employer/Union Direct Contract Private Fee-for-Service | ED PFFS |
| **Demonstration Plans:** | |
| Continuing Care Retirement Community | CCRC |
| Social HMO | SHMO |
| Minnesota Disability Health Options | MN DHO |
| Minnesota Senior Health Options | MN SHO |
| Wisconsin Partnership Program | WI PP |
| Massachusetts Health Senior Care Options | MA HSCO |

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

**Line 9 – Enrollee Type**. If the bid prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, enter "A/B". If the bid prices any type of plan covering enrollees eligible for Part B only, enter "Part B Only".

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

For regional PPO plans, valid entries are as follows:

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

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

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

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

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

## SECTION II – BASE PERIOD BACKGROUND INFORMATION

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

For example, if the incurral period is calendar year 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, the "paid through" date is 2/28/2006.

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

CMS recommends that plans should not rely solely on CY2006 year-to-date claims experience for the CY2007 projection.

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

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

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

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

**Line 4 – Completion Factor**. Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date. The factor entered must be the amount to adjust only the portion of paid claims that requires completion (i.e., omit capitations from the calculation of this factor).

For example, assume:

| | |
|---|---|
| Incurred Date | 1/1/2005 – 12/31/2005 |
| Paid Through Date | 2/28/2006 |
| | |
| Capitation Payments | $100 |
| PTD Claims Requiring Completion | $400 |
| Estimate of Unpaid 2005 Claims as of 2/28/2006 | $30 |
| Total Incurred Claims for 2005 | $530 |

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

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

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

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

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

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

**General Considerations.**

CMS recommends that plans should not rely solely on CY2006 year-to-date claims experience for the CY2007 projection. While we generally expect the experience data to be based on a 12-month incurral period with *at least* 30 days paid run-out (e.g., 2 - 3 months of paid claim run-out), we do not require that the base experience incurral period be a calendar year.

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

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

Note that these data:

- Need *not* exactly match the benefit plan or service area for the bid (see Section II instructions). Section IV will address adjusting the base period data to the contract year benefit plan and service area.
- Reflect either calendar year or other *annualized* experience.
- Reflect the current best estimate of incurred claims on an experience basis, including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin on Worksheet 4).
- Include any provider incentive payments.

- Include total services (both in-network and out-of-network, Medicare-Covered and additional services).
- Reflect costs before any reduction for member cost sharing and reinsurance recoveries (i.e., the experience data must be on an allowable basis).
- Exclude the value of extra EGWP benefits added to employer-only group plans as a result of negotiations with employers/unions.
- Include capitations allocated to the appropriate service category line on a reasonable basis.
- Exclude ESRD claim experience.

Appendix G contains a suggested **mapping of benefit categories** between the PBP software and the bid pricing tool. In addition, the CY2007 Call Letter contains information regarding "what is considered a benefit" for MA plans. The Medicare Managed Care Manual may also be a helpful resource regarding benefit definitions.

**Service category lines** can be one of three types:

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

The costs for lines a through k, p, and s will be distributed to Medicare-Covered and Non-Covered benefits based on the percentages entered in Worksheet 4 columns h and i.

**POS** experience data may be included in the appropriate service category (in lines a through o and q through s), with nothing entered in the POS service category (line p). Alternatively, the plan may enter the POS experience in line p. If an organization chooses to enter the cost of POS benefits in the POS line p, the user must input the percentage allocation for Medicare-Covered services in Worksheet 4. (This is a change from the CY2006 bid form, in which benefits entered in the POS service category were considered 100% Non-Covered.)

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

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

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

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

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

**Column f, Lines a through r** – **Utilization type**. The type of utilization *must* be entered in column f. Do not leave this column blank. For each service category line, enter the appropriate utilization type that reflects the annualized utilization/1000 enrollees entered in column g. The valid utilization types are listed below. Note that the valid utilization types vary by service category.

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

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

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

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

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

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

## SECTION IV – PROJECTION ASSUMPTIONS (COLUMNS J THROUGH P)

Section IV presents the utilization, average unit cost, and other adjustment assumptions to project the base period data to the contract period. The factors in columns j through n are

the *total* adjustment factor from the base period to the contract period, not annual trend rates. For example, assume that the base period is calendar year 2005 and that the contract year is 2007. If the utilization trend is 5% from 2005 to 2006 and 6% for projecting 2006 to 2007, then enter 1.113 in column j (1.05 x 1.06).

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

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

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

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

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

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

**Columns o and p, Lines a through s** – **Additive Adjustments**. Use these columns to reflect adjustments that are additive (adjustments in columns j through n are multiplicative factors). For example, a benefit that is no longer being offered but is included in the base period data might need to be deleted/removed. In this case, enter the projected PMPM of the benefit being removed as a negative number in column p. Do not input an additive utilization adjustment for COB (line s, column o) since there is no base period utilization for COB. Describe the reason for any additive adjustments in Section V.

## SECTION V – DESCRIPTION OF OTHER UTILIZATION FACTOR AND ADDITIVE VALUES

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

# Worksheet 2 - MA Projected Allowed Costs PMPM

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

All information provided on Worksheet 2 must exclude ESRD enrollees.

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

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

## SECTION I - GENERAL INFORMATION

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

## SECTION II – PROJECTED ALLOWED COSTS

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

**Lines a through s.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Worksheet 3 - MA Projected Cost Sharing PMPM (In- & Out-of-Network)

Worksheet 3 summarizes the expected MA cost sharing for the contract year and includes both in-network and out-of-network cost sharing. This worksheet is the combination of Worksheets 3A and 3B used in last year's (CY2006) bid form.

All information provided on Worksheet 3 must exclude ESRD enrollees.

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

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

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

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

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

## SECTION I - GENERAL INFORMATION

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

## SECTION II – MAXIMUM COST SHARING PER MEMBER PER YEAR

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

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

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

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

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

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

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

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

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

*Option A*:

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

*Option B*:

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

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

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

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

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

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

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

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

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

*Option C*: Enter all services on one line (e.g., i2 or i6) using average copays.

| | col g | col h | col i | col j |
|---|---|---|---|---|
| Line i2 or i6 | 8,000 | $10/visit PCP<br>$20/visit non-MH specialist<br>$20/visit for group MH<br>$40/visit for individual MH | $ 13.88 | $ 9.25 |
| Total | 8,000 | | $ 13.88 | $ 9.25 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Worksheet 4 - MA Projected Revenue Requirement PMPM

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

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

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

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

## SECTION I - GENERAL INFORMATION

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

## SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

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

**Lines a through u.**

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

**Column f – Cost Sharing for Total Benefits**. The total in- and out-of-network cost sharing PMPMs are obtained from Worksheet 3. No user inputs are necessary.

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

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

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

For services that are Non-Covered as defined, the percentage is set equal to 0.0% (see lines l through o and q through t). For all other services, the plan must estimate the percentage of Covered Services for both the allowed costs and the cost sharing. The user must enter these percentages in columns h and i.

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

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

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

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

**Column j – Fee-for-Service Medicare Actuarial Equivalent (AE) Cost Sharing Proportions.** These values are pre-populated by CMS.

**Column k – Plan Cost Sharing for Medicare-Covered Services**. This column represents the portion of the plan's cost sharing that is allocated by the user to Medicare-Covered services, calculated as column f times column i. This column is also used to determine the Reduction of A/B Cost Sharing in column p.

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

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

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

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

**Columns o through q – A/B Mandatory Supplemental (MS) Benefits.** These columns are calculated automatically and are the basis for the costs included in the A/B Mandatory Supplemental Premium. Note that the calculations and information contained in these columns have changed since the CY2006 bid form.

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

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

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

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

**Line w – Non-Medical Expenses**. The user must enter the non-medical expense information for total MA benefits in column g for the four categories described below.

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

The systematic distribution of non-medical expenses is a change since the CY2006 bid form, where the distribution was manually entered by the user. Responding to industry comments from last year, the bid form's formulaic allocation may prevent user-entered errors and reduce resubmissions in order to correct such errors. The formulaic allocation also provides for consistency among all plans and consist methodology between MA and Part D bid forms.

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

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

medical management, claims administration, etc.). In the CY2007 MA BPT, Medicare User Fees and Uncollected Enrollee Premium must be reported under Direct Administration (this is a change from the CY2006 MA bid form).

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

All non-medical expenses must be reported using the appropriate generally accepted accounting practice (GAAP) methodology (to the extent this is consistent with the MAOs standard accounting practices, if the MAO is not subject to GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to relevant GAAP principles. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability is FASB's Statement of Financial Accounting No. 60, Accounting and Reporting by Insurance Enterprises.

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

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

- Expenditures for tangible assets must be capitalized and amortized according to relevant GAAP principles, e.g., a new computer system purchased by a non-profit MAO in 2005.
- Expenditures for non-tangible assets, e.g., salaries and benefits, must be reported consistent with the MAOs internal accounting practices and the reporting of similar expenditures in other lines of business.

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

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

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

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

**Lines w1 through w4 - Non-Medical Expense.** Total non-medical expenses are input in column g and allocated proportionately between Medicare-Covered (column n) and A/B Mandatory Supplemental (column q). Note that the same proportion is used for each line item. The proportional allocation is based on the relative proportion of the plan's revenue requirements for Medicare-Covered ("bid") and A/B Mandatory Supplemental, excluding the PMPM impact of the ESRD subsidy.

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

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

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

**Line w5, columns g, n, and q - Total Non-Medical Expense.** This amount is the sum of lines w1 through w4.

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

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

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

The systematic distribution of gain/loss is a change since the CY2006 bid form, where the distribution was manually entered by the user. Responding to industry comments from last year, the bid form's formulaic allocation may prevent user-entered errors and reduce resubmissions in order to correct such errors. The formulaic allocation also provides for consistency among all plans and consist methodology between MA and Part D bid forms.

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

One component of the bid's review by CMS will be assessment of the reasonableness of the gain/loss margin relative to other MA bids. Organizations will be required to provide justification of the margin for bids with relatively large projected gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii)

demonstration of corporate return requirement(s), and/or (iii) other supporting documentation. The development of margin requirements may reflect revenue offsets not captured in non-medical expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

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

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

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

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

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

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

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

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

**Line 1. Standardized FFS Cost Sharing for Medicare-Covered Services.** This value is pre-populated by CMS. No user input is required.

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

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

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

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

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

The benchmarks calculated in the CY2007 MA bid form exclude enrollees in ESRD status, as does the projection of plan expenditures. However, all individuals enrolled in the plan, including those in ESRD status, are required to pay the same plan premium and are offered the same benefit package. In an effort to account for the projected marginal costs (or savings) of plan enrollees in ESRD status, Section IV allows for an adjustment. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits.

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

Bids that are based on a credible block of ESRD experience are expected to complete the ESRD fields for basic, or Medicare-Covered, benefits. (Obviously, due to the higher expected level of per-enrollee expenditures, the credibility thresholds for individuals in ESRD status will typically be lower than those based on non-ESRD populations.) Organizations that complete this section are *required* to submit supporting documentation for this adjustment, including base period (e.g., 2005) revenues and medical expenditures for Medicare-Covered benefits provided to enrollees in ESRD status, relevant base-to-contract year trend factors, and a short narrative on the credibility approach applied to the ESRD experience.

The applicable fields to be completed in the Medicare-Covered section are (i) projected CMS capitation, (ii) projected medical expenses, and (iii) projected non-medical expenses. The projected margin requirement is calculated based on the values for the non-ESRD bid. All fields in this section are to reflect Medicare levels of cost sharing (e.g., 20 percent cost

sharing for Part B services once the deductible has been met) and must be reported on a "per ESRD member per month" basis.

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

The Mandatory Supplemental part of Section IV *must* be completed for all bids that reflect credible Medicare-Covered experience for enrollees in ESRD status. Bids that do not have credible Medicare-Covered experience are encouraged to reflect this incremental cost for supplemental A/B benefits. The inputs in this section are (i) the projected cost sharing reduction PMPM for ESRD enrollees, and (ii) the projected PMPM cost of additional benefits for ESRD enrollees. Entries must be reported on a "per ESRD member per month" basis.

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

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

This section is a change since the CY2006 bid form. As discussed in the CY2007 Call Letter, CMS is currently evaluating methodological approaches for including ESRD enrollee costs in the plan bids for CY2008.

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

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

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

See Appendix D for further information on group bids.

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

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

# Worksheet 5 - MA Benchmark PMPM

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

All information provided on Worksheet 5 must exclude ESRD enrollees.

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

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

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

- Section II – Summarizes the development of the benchmarks and bids.
- Section III – Summarizes the development of the Savings or Basic Member Premium.
- Section IV – Development of Regional A/B Benchmark (using the Statutory Component of Regional Benchmark).
- Section V - Projected plan-specific information for counties within the service area.
- Section VI – Other Medicare Information (pre-populated by CMS).
- For certain demonstrations only:
    - Section VII – Demographic inputs section.
    - Section VIII – Demographic weighting, pre-populated by CMS.

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

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

# SECTION I - GENERAL INFORMATION

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

## SECTION II – BENCHMARK AND BID DEVELOPMENT

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

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

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

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

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

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

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

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

## SECTION III – SAVINGS/BASIC MEMBER PREMIUM DEVELOPMENT

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

**Line 2 – Rebate**. This value is defined as 75% of the Savings.

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

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

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

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

**Line 2 – Plan Bid Component.** The plan bid component will be announced by CMS after the regional bids are initially submitted. The RPPO regional average bids are generally announced by CMS in early August. However, plans may input an estimated amount.

For bids that are submitted prior to the announcement of the RPPO averages, there are two options for completing this field: (i) leave the cell blank, in which case the submitted bid (Section II, line 7) is used as the Plan Bid Component, or (ii) input a reasonable estimate of the average CY2007 RPPO bid for the region.

The RPPO announcement includes the weighted average MA RPPO bid for each region. Organizations will be instructed to submit revised bids with the applicable average bid entered into Line 2.

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

**Line 4 – Stabilization Fund Adjustment.** This field is used to accommodate any bonuses available from the MA Regional Plan Stabilization Fund, in accordance with Section 1858(e) of the Social Security Act.

Guidance is forthcoming on the criteria to be used by CMS to determine the amount of these bonuses, if any.

**Line 5 – Standardized A/B Benchmark.** This field is a calculated value based on lines 3 and 4. No input is required.

**Line 6 – Stabilization Funding (PMPM).** This field will not be used in the CY2007 bid submissions. Do not enter any values into this cell**.**

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

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

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

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

**Line 2 – Total or Weighted Average for the Service Area**. The county-level data are weighted by projected enrollment.

**Line 3 – County-Level Detail.**

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

- Each State-County code must be entered as a text input (i.e. must include a preceding apostrophe) and include all leading zeroes (e.g., '01000). This field has been formatted as the "General" format in Excel, in order to support the functionality to link spreadsheets. Therefore, county codes must be entered as text (i.e., using a preceding apostrophe) including any leading zeros.
- If the service area has more than one county, do not leave any blank rows between the first and last State-County code entered.
- Do not enter the same State-County code more than once.
- Do not insert any additional rows in the worksheet.
- Do not input the out-of-area (OOA) county, "99999". OOA enrollees are not represented in the benchmark calculation.

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

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

**Column e – Projected Member Months (excluding ESRD)**. Enter the projected contract year member months (not average monthly membership, as was reported in last year's bid form). The projected member months must include both aged and disabled members, but exclude ESRD members. The projected member months should be developed using data on members enrolled in the plan as of early 2006.

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

**Changes to Risk Score Development for 2007**

The goal of the risk score development is to develop a plan average risk score for the projected 2007 population. CMS has re-estimated the CMS-HCC risk model on which risk scores are determined for 2007; we refer to this re-estimated model as the "recalibrated" or "new" model. Because the CMS-HCC model has been recalibrated, the appropriate starting point to develop a projected 2007 risk score is a score calculated under the **new** CMS-HCC model. In order to facilitate the development of an appropriate 2007 score, CMS will provide information on plan average scores under the new model for all existing MA and MA-PD plans with enrollment as of May 2006, using CY 2005 diagnoses (with run-out through 4/1/2006).

Additionally, FFS normalization, a process which adjusts risk scores to a 1.000 average for each payment year, will be applied to risk scores calculated under the new model. FFS normalization of the risk scores produced by the model will take place prior to payment in 2007 and for subsequent years. The normalization factor that will

be applied in 2007 is 1.029 (that is, risk scores will be divided by 1.029). In 2006, under the original CMS-HCC model, FFS normalization was incorporated into the benchmarks; thus no adjustment was made in the development of the risk scores.

**Risk Score Development for New Plans**

Acceptable approaches for the development of risk scores depends on whether or not the plan is new or exists currently. New plans (i.e. those plans not expected to enroll existing MA enrollees) should estimate risk scores based on the expected medical expenses for their projected enrollees. Further, the risk scores for new plans must be developed based on the new CMS-HCC model, which can be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/, under "risk adjustment".

**Risk Score Development for Existing Plans**

The preferred method for development of projected risk scores for existing plans is:

1. Use a plan average risk score computed under the new CMS-HCC model as the basis for risk score development. Plan average risk scores under the new model, computed by CMS, will be provided to existing MA and MA-PD organizations through HPMS. Organizations also have the option to calculate a risk scores for their enrollees using the 2007 CMS-HCC risk adjustment software available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. Organizations that calculate risk scores using the new model software must appropriately assign beneficiaries to the correct version of the model (community, institutional, or new enrollee). New enrollees are defined as beneficiaries with less than 12 months of Medicare Part B enrollment in the data collection period. Organizations should make appropriate adjustments to account for incomplete diagnosis data for full-risk enrollees for whom they do not have 12 complete months of diagnostic data in the data collection period (i.e. those beneficiaries newly enrolled to the plan from FFS or from another MA organization) otherwise their average risk score will be underestimated for the projected population.

2. Adjust the new CMS-HCC risk scores as follows:
    a. Adjust for seasonality. CMS has consistently found that average plan risk scores decline throughout the payment year. Our research indicates the risk scores decline on average about 0.57% per month due to changes in the insured population; however, your plan's experience may vary and you should adjust accordingly. Typically, a plan's risk score is average for the year in the month of July. Therefore, a reasonable adjustment is to multiply your May risk score by 0.9886.
    b. Adjust for the impact of submitting diagnoses data after April 1, 2006 (i.e. late data). MA and MA-PD have approximately 12 months after the end of the data collection year to submit additional diagnostic data which impact their final risk score. Our experience shows that the average effect of data submitted after March of the contract year is to increase risk scores by 2.5%. Again, each plan's experience will vary and you should adjust your projected risk score accordingly.

c. Adjust for projected change in risk score from 2006 to 2007. Plan risk scores may be projected to change between 2006 and 2007 for a variety of reasons, notably changes in the characteristics of the projected enrolled plan population and/or improvements in diagnostic data collection and submission. Plans should use their historical experience to project risk scores to 2007.
d. Divide the 2007 plan projected risk score by the 2007 FFS normalization factor. The 2007 FFS normalization factor is 1.029. This step ensures that the projected risk score used to calculate the bid and benchmark is adjusted in the same manner as payments will be adjusted in 2007.

Example of Risk Score Development for Hypothetical Plan

| | Base Score/ Adjustment | Adjusted Score for use in 2007 Bid | Comments |
|---|---|---|---|
| New CMS-HCC Risk Score (Enrollment as of May 2006 MMR) | 1.00 | 1.00 | Hypothetical Plan Risk Score under new CMS-HCC model using calendar year 2005 diagnoses data w/ run out through 4/1/2006 |
| Seasonality Adjustment | 1.00 * (1 - .0057)^2 | .9886 | Base risk score adjusted to July 2006 to reflect average plan score for calendar year 2006 |
| Late Data Adjustment | .9886*1.025 | 1.0133 | Adjustment for late data submitted after 4/1/2006 and prior to 1/31/2007 |
| 2006-2007 plan risk score change projection | 1.0133*1.03 | 1.0437 | Hypothetical adjustment for projected changes in the health status of the plan's enrollment between 2006 and 2007 |
| FFS Normalization of 2007 projected plan risk score | 1.0437/1.029 | 1.0143 | Application of FFS normalization factor to the projected 2007 risk score |

Notes: Adjustments for seasonality and late data are based on CMS data modeling, 2006-2007 plan risk score change adjustment projection is purely hypothetical, FFS normalization adjustment will be applied to payment in 2007.

Thus, the resulting risk score to be input into Worksheet 5, Section V, column f, of the 2007 MA bid pricing tool is 1.0143. Please note, that the above example would typically apply to individuals enrolled in all counties in the plan's service area.

Reminder: The new model risk scores released March 31, 2006 through HPMS, which were used for CMS' analysis of the impact of the new CMS-HCC model, are based on an earlier cohort (July 2005) and an earlier data collection period (CY 2004 diagnoses).

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

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

(i) Enter "yes" in line 1, in response to the question: "Use of plan-provided ISAR?" (Technical note: Do not enter "Y" in this field – enter the entire word "yes")
(ii) Enter the plan-provided ISAR factors in column g of the county-level detailed table. Factors can be in the form of either a PMPM value or a relative scale.
(iii) Provide support for the development of the plan-provided ISAR factors in accordance with Appendix B.

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

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

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

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

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

## SECTION VII – OTHER MEDICARE INFORMATION

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

**Columns n through q – Original Medicare Cost Sharing Proportional Factors**. These columns will be populated by CMS and are used in column j of Worksheet 4.

**Columns r through u – FFS Costs used to weight Original Medicare Cost Sharing**. These columns will be populated by CMS and are used in the first line of columns n through q of Worksheet 5.

**Columns v through w – FFS Equivalent Cost Sharing**. These columns will be populated by CMS and are used in Section III of Worksheet 4.

**Columns x through y – Metropolitan Statistical Area (MSA)**. These columns will be populated by CMS. While not directly used in the BPT calculations, this information is helpful to CMS during bid reviews.

## SECTION VII – DEMOGRAPHIC INPUTS, USED BY CERTAIN DEMONSTRATION PLANS ONLY

This section is similar to Section V but contains county-level *demographic* aged and disabled information. Certain demonstration plan types are on a delayed transition schedule to Risk rates. The following plan types must complete this section:

| Plan type | Plan Type Code |
|---|---|
| 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 |

All other plan types may leave this section blank.

**Column z – Demographic Aged Member Months**. Calculated as the difference between column e and column aa.

**Column aa – Demographic Disabled Member Months**. Similar to column e, but for *disabled* member months only.

**Column ab – Aged Demographic Factor**. Similar to column f, but for *aged* members (for use with the Aged demographic Ratebook).

**Column ac – Disabled Demographic Factor**. Similar to column f, but for *disabled* members (for use with the Disabled demographic Ratebook).

**Columns ad through ae – Plan-Provided ISAR Factors**. Similar to column g, but for Aged and Disabled demographic rates.

**Columns af through ag – MA Ratebook : Unadjusted**. Similar to column h, but for Aged and Disabled demographic rates.

**Columns ah through ai – MA Ratebook: Risk-Adjusted**. Similar to column i, but for Aged and Disabled demographic rates.

**Columns aj through ak – ISAR Scale**. Similar to column j, but for Aged and Disabled demographic rates.

**Columns al through am – ISAR-Adjusted Bid.** Similar to column k, but for Aged and Disabled demographic rates.

**Columns an through aq– Demographic Payment Rates**. Similar to columns l through m, but for Aged and Disabled demographic rates.

## SECTION VIII – RISK/DEMOGRAPHIC WEIGHTING FOR CERTAIN DEMONSTRATION PLANS ONLY

This section will be populated by CMS and used for certain demonstration plans only.

# Worksheet 6 – MA Bid Summary

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

All information provided on Worksheet 6 must exclude ESRD enrollees.

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

- RPPO risk sharing (see Appendices B and H).

## SECTION I - GENERAL INFORMATION

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

## SECTION II – OTHER INFORMATION

### *Section A – Part B Information*

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

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

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

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

The amount shown here is the estimated value of the standard Part B premium for the contract year at the time that the bid form is released.

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

**Line 2 – Part B % of USPCC**. This value is pre-populated by CMS. For "Part B Only" bids, this percentage is used to estimate the Part A portion of the CMS benchmark, which is one of the tests for the maximum amount that the MAO may charge Part B-only members for Part A benefits.

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

### *Section B – Rebate Allocation for CY Standard Part B Premium*

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

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

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

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

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

## SECTION III – PLAN A/B BID SUMMARY

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

### *Section A – Overview*

This section summarizes the required revenue for the plan.

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

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

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

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

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

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

## *Section B – MA Rebate Allocation*

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

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

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

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

**Line 1 – MA Rebate Available**. The amount calculated on Worksheet 5 is shown on this line.

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

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

The following rules apply for rebate allocations:

- The fifth column of this section shows the maximum amount that may be applied for each rebate option. Each rebate allocation cannot exceed the applicable maximum.

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

- No rebate allocations may be negative.

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

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

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

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

- Rebates allocated to buy down the estimated standard Part B Premium are subject to the maximum amount shown on Worksheet 6. This maximum is the estimated CY2007 standard Part B premium at the time when the bid form is released by CMS. See the instructions for Section IIB for further information about rebates applied to the standard Part B premium.

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

## *Section C – Development of Estimated Plan Premium*

The MA Bid Pricing Tool calculates the plan's premium for services under the Medicare Advantage program. Part D premiums (calculated in the separate Part D BPT) were added to the CY2007 MA BPT in order to:

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

When the bid is initially submitted in June, the Part D Basic premium entered in the MA BPT is an *estimated* value. The *actual* premium will be calculated by CMS when the Part D National Average Bid Amount is determined (generally in early August). Therefore, for MA-PD plans, the premium shown on the MA BPT may not be the final plan premium for CY2007.

For local MA-only plans, the premium shown on the MA BPT upon initial submission in June is the final actual premium (*not* an estimate) since they are not affected by the Part D National Average or Regional PPO benchmark calculations. Local MA-only plans *do not*

have an opportunity to resubmit in August for rebate reallocations. The initial bid submission in June must reflect the desired plan premium.

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

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

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

Additional information regarding rounding premiums and rebate reallocation, including examples, are available in the CY2007 Call Letter.

It is important to note that for **all** plans, the initial June bid submission must reflect the desired level of premium rounding.

Plans must identify, in the CY2007 MA BPT, their intention for the Part D target premium *in their initial June bid submission*. See instructions for line 10 of this section for further information on the Part D target premium.

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

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

**Line 3 – A/B Mandatory Supplemental Premium**. The sum of lines 1 through 3.

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

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

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

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

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

Line 7d calculates the estimated Part D Basic Premium net of rebates.

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

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

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

Line 8d calculates the Part D Supplemental Premium net of rebates.

**Line 9 – Total Estimated Plan Premium.** The sum of the rounded MA, Part D Basic, and Part D Supplemental premiums.

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

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

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

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

In this section, enter the name, position, phone number, and email information for the plan contact as well as for the certifying actuary. For the phone number, enter all 10 digits consecutively without parentheses or dashes. Also, if a contact person has no email service, enter "none".

The person named as the plan contact must be available for any actuarial issues that arise during the review of the bid form by CMS.

Section IV also contains a field labeled "Date Prepared." This field must contain the date that the bid was prepared. The accompanying actuarial certification must indicate this date. When the actuarial certification is resubmitted at the end of the bid review process, the final certification must be updated to reflect this BPT identifier, as well the accompanying PBP identifier. See Appendix A for further information.

## SECTION V – DEVELOPMENT OF RISK SHARING TARGET (REGIONAL PLANS ONLY)

This section calculates the medical benefit ratio target, based on the information contained in the bid. It is applicable to regional plans only. No user inputs are required. However, in accordance with Appendices B and H, organizations must provide as a supporting exhibit a description of the adjustments that will be made to medical costs reported in the general ledger to account for (i) any differences in the level of cost sharing reflected in the risk sharing target and that required of plan enrollees, and (ii) the methodology to be used to capture expenditures for Non-Covered services that are implicitly included in the risk sharing target.

## SECTION VI – DEVELOPMENT OF CLAIM ADJUSTMENT RATIO (REGIONAL PLANS ONLY)

This section calculates the claim adjustment ratio, based on the information contained in the bid. It is applicable to regional plans only. No user inputs are required. However, in accordance with Appendices B and H, organizations must provide as a supporting exhibit a description of the adjustments that will be made to medical claims.

# Worksheet 7 – Optional Supplemental Benefits

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

The worksheet allows for five optional supplemental packages to be priced, with 20 category lines for each package. If additional category lines are needed, provide a supporting exhibit that shows all of the benefit category details, and include a summary of those category lines on this worksheet. Do not insert any additional rows into the form.

All information provided on Worksheet 7 must exclude ESRD enrollees.

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

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

## SECTION I - GENERAL INFORMATION

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

## SECTION II – OPTIONAL SUPPLEMENTAL PACKAGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Column q - Projected Member Months.** Enter the total projected contract year *member months* for each optional supplemental package offered (not average members, as reported in the CY2006 BPT).

## SECTION III - COMMENTS

Enter any comments needed to describe the optional benefit packages.

# Two-Year Look-Back Form

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

The form requires the user to input actual incurred revenue and expense information for the calendar year two years prior to the contract year being priced. For example, in contract year 2007, the experience year is 2005. CMS will compare the actual amounts entered in this form to the original projection (i.e., the 2005 ACR in contract year 2007).

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

**Contract Number**. Displays the contract number.

**Organization Name**. Displays the organization name.

**Contract Year**. Displays the contract year.

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

**Line 1. Revenue**. Columns f and g (Original Projection) should be populated with information from CMS. This information will be the weighted average of the 2005 ACR values, with the weights being the Medicare Membership Report (MMR) actual member months for each PBP included in the contract. Column h is the weighted average of columns f and g. The user must enter data into columns j and k (Actual Incurred). Column l is the weighted average of columns j and k. Columns n, o, and p calculate the ratio of actual-to-projected and do not require any user input.

The CMS-reported revenue is reduced for funds placed in the benefit stabilization fund and increased for monies withdrawn from the fund. Also, the CMS-reported revenue figures are net of BIPA 606 Part B premium withholds.

**Line 2. Net Medical Expenses**. Columns f and g should be populated with information from CMS. This information will be the weighted average of the 2005 ACR values. Column h is the weighted average of columns f and g. Columns j and k refer to data entered in footnote 2. Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

The net medical expenses are to be reported on an experience (or incurred) basis, rather than GAAP (or accounting year) basis. Additionally, for CY2007, results for additional prescription drugs must be reported in line 2b as A/B Mandatory Supplemental Benefits.

**Line 3. Non-Medical Expenses**. Columns f and g should be populated with information from CMS. This information will be the weighted average of the 2005 ACR values. Column h is the weighted average of columns f and g. The user must enter data in columns j and k.

Column l is the weighted average of columns j and k. Columns n, o, and p do not require user input.

Please note that the administration line included in the 2005 ACRP represents several non-medical expense components that must be reported separately for 2007: (a) marketing & sales; (b) direct administration; (c) indirect administration; and (d) net cost of private reinsurance. The CMS value for these items is reflected in the "direct administration" line. Similarly, organizations are given the flexibility to combine the actual sales, marketing, and administration expenses for 2005 into the "direct administration" line.

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

**Line 5. Key Statistics**.

> **Line 5a - Member Months.** Columns f and g, should be populated with information from CMS, based on MMR data. The user must enter data in columns j and k.
>
> **Line 5b - Non-ESRD Risk Factor.** The data for columns f and g will *not* be provided by CMS for CY2007. Medicare Advantage Organizations may either populate their 2005 risk scores for individual plans (column j) and employer-only group plans (column k) or leave this line blank in CY2007..
>
> **Lines 5c, 5d, and 5e.** These fields are calculated automatically. No user input is required.

**Footnote 2:**

**Incurred in Experience Year and Paid Through**. The user must enter the paid through date.

**Net Medical Expenses**.

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

**Footnote 3:**

**Actual Incurred components of Net Reinsurance**.

a. **Private Reinsurance Premium.** The user must enter data in the first two columns.

**b. Private Reinsurance Recoveries**. The user must enter data in the first two columns.

**c. Net Reinsurance Cost**. The sum of lines a and b.

# Appendix A – Actuarial Certification

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

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

## Actuarial Standards of Practice

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

- ASOP No. 5, Incurred Health and Disability Claims.
- ASOP No. 8*, Regulatory Filings for Rates 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 the following sections: Analysis of Issues and Recommended Practices, Communications and Disclosures.
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage.
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking.

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

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

## Resubmission of Actuarial Certifications

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

**Final Actuarial Certification**

Toward the end of the CY2007 bid review process (likely in August), each plan will be required to resubmit a final actuarial certification. As indicated in the previous section, no material changes to the certification language will be considered, without prior permission from OACT. The actuarial certification submitted in early June with the initial bid submission will be considered the definitive certification.

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

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

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

The identifying information above (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

Note that the mailed (paper) copy must contain the exact same language as the electronic submission. The electronically submitted certification is considered the definitive version, as no changes contained in the paper version will be considered.

- Name of the certifying actuary, title, employing firm, contact information, credentials, qualifications, and relationship of the actuary to the organization submitting the bid. As indicated at the beginning of this appendix, the certifying actuary must be a member of the American Academy of Actuaries (MAAA).
- The date of the certification.
- The specific contract, plan ID(s), and segment ID(s) associated with the certification.
- The Contract Year of the bid(s) contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Prescription Drug bid, or both.
- The date that the bid pricing tool was prepared (must match the date entered on BPT Worksheet 6 for MA and Worksheet 7 for PD).
- The 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).
- In accordance with ASOP No. 8, the actuary should consider the business plan for the organization as part of the setting of assumptions and methodologies used in the bid.
- Attestation that the bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries and that the bid complies with the appropriate ASOPs.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this reliance must be disclosed in the certification. Any reliance must be in accordance with ASOP No. 23.
- Limitations and qualifications.

**Sample Language**

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

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

| Organization Name: | | Health One | | | | |
|---|---|---|---|---|---|---|
| Bid ID (Contract - Plan - Segment) | Cert. For MA bid? | MA BPT Date Prepared (w6) | MA PBP HPMS version # | Cert. For PD bid? | PD BPT Date Prepared (w7) | PDP PBP HPMS version # |
| H9999-001-00 | Y | 05/15/2006 | 1 | Y | 05/20/2006 | 1 |
| H9999-002-00 | Y | 05/04/2006 | 1 | N | | |
| 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).
- The data and assumptions used in the development of the bid are consistent with the organization's current business plan.
- The bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

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

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

Sincerely,

[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.

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

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

# Appendix B – Supporting Documentation

In addition to the bid form and actuarial certification, organizations must provide CMS with supporting material. All data submitted as part of the bid process are subject to review and audit by CMS or by any person or organization that CMS designates.

In order to complete the MA bid form, MAOs must complete a series of calculations and enter the results in the appropriate worksheet. Therefore, it is required that any relevant supporting information be summarized and included with the bid submission to CMS. Supporting materials are to be in electronic format (i.e., Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. 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.

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. Also, files can be uploaded to multiple plans in HPMS by using the CTRL key when selecting plans.

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

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

***Required Documentation***

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

- A signed actuarial certification (see Appendix A for more information on the required elements of actuarial certifications).
- Support for the credibility assumptions (Worksheet 2), if the assumptions differ from the CMS guidelines included in these instructions.
- Support for the manual rate development (Worksheet 2), if a manual rate is used.
- Support, at the benefit level, for any significant projected allowed costs (i.e., PMPM > $5.00) for Non-Covered services (Worksheet 2, lines l through r, columns m through o).
- Detailed description of the process used for adjusting cost sharing due to maximum out-of-pocket limits (Worksheet 3).

- Support for the cost sharing test if a plan does not fall within the allowable limit (Worksheet 4, Section III).
- Support for the development of the Contract Year ESRD "subsidy" for Basic Benefits (Worksheet 4).
- In accordance with Appendix D, support for actuarial swaps/equivalence customization allowable for employer and union groups enrolled in individual-market plans (if used, indicated in the General Information section of Worksheet 1).
- Support for the development of plan-provided ISAR factors (Worksheet 5), if used (Regional PPOs only). A description of the methodology and data source(s) used to calculate the ISAR scale(s) must be included. The factors must reflect the requirements for medical expense, non-medical expense, and gain/loss margin. Additionally, the support must illustrate the county-level medical costs (such as unit costs and/or utilization) and retention (i.e., non-medical expense and gain/loss margin) that were assumed in the development of the factors.
- Support for the development of projected risk scores (Worksheet 5).
- Regional plans that are not employer-only group plans (i.e., not "800-series" plan IDs) must provide a description of the methodology that will be used to develop actual revenue and medical expenses to be included in the risk sharing reconciliation. See Appendix H – Regional Plan Risk Sharing (Worksheet 6).

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

- Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
- Support for projection assumptions (Worksheet 1).
- Support for cost sharing utilization assumptions and plan level deductible (Worksheet 3).
- Support for allocation of allowed costs and cost sharing between Medicare-Covered and A/B Mandatory Supplemental benefits (Worksheet 4).
- Support for non-medical expense assumptions (Worksheet 4). This documentation could include further analysis of non-medical expense categories (separating claim adjudication, network management, customer service, etc.). In addition, distinctions between start-up versus ongoing costs and fixed versus marginal costs may be examined by CMS.
- Justification of the margin for bids with relatively large or unreasonable projected gains/losses relative to other bids, including other bids submitted by the same organization. Examples of such justification are (i) illustration of return on investment /equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other actuarial support. The development of the margin requirements may reflect

revenue offsets not captured in non-medical expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income (Worksheet 4).

- Non-medical expenses and gain/loss margin for Optional Supplemental Packages that are not consistent with the assumptions of the Basic Bid (Worksheet 7).
- Communication between CMS reviewers and the organization throughout the bid review process (i.e., e-mail communication).
- Additional information may be requested by CMS reviewers, as needed.

# Appendix C – Part B-Only Enrollees

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

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

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

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

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

# Appendix D – Medicare Advantage Products Available to Groups

(Employer Groups and Union Groups)

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

## Individual-Market Plans ("mixed enrollment" plans)

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

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

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

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

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

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

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

Under Sections 1857(i) of the Social Security Act (SSA), CMS may waive or modify requirements for these kinds of arrangements that "hinder the design of, the offering of, or the enrollment in" these employer or union-only sponsored group plans. CMS may exercise

its statutory waiver authority for two basic types of MA plan entities: (1) MA organizations that offer or administer employer/union-only sponsored group waiver plans ("EGWPs" or "employer-only group plans"); and (2) employers/unions that directly contract with CMS to themselves offer an employer/union-only sponsored group waiver plan ("Direct Contract" EGWPs).

For CY2006, CMS issued guidance waiving or modifying a number of requirements for these entities. CMS waiver guidance is located at: http://cms.hhs.gov/EmpGrpWaivers .

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

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

- Each employer-only group bid must reflect the composite characteristics of the individuals expected to enroll in the plan for Contract Year 2007. These assumptions include, but are not limited to, the following: risk scores, geographical distribution of enrollees, benefit package, non-medical expenses, and gain/loss margins.

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

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

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

- The following are the guidelines for rebates:

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

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

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

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

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

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

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

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

# Appendix E – Plans Serving Qualified Medicaid Beneficiaries (QMBs)

***Please see the CY2007 Call Letter for information regarding bidding guidance for plans serving QMBs.***

http://www.cms.hhs.gov/HealthPlansGenInfo/08_LettersandAnnouncements.asp#TopOfPage

# Appendix F – Rebate Reallocation Period

***Please see the CY2007 Call Letter for information and examples regarding the rebate reallocation period for CY2007 bids.***

http://www.cms.hhs.gov/HealthPlansGenInfo/08_LettersandAnnouncements.asp#TopOfPage

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

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

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

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

HPMS contains a "Medicare Benefit Description Report" with further information regarding the PBP service categories. The CY2007 Call Letter also contains information on "what is considered a benefit" for MA plans. In addition, the *Medicare Managed Care Manual* may be a helpful resource regarding benefit design.

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

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

# Appendix H – Regional Plan Risk Sharing

Section 1858(c) of the Social Security Act provides for risk sharing to be in effect for regional MA plans. CMS is not sharing the risk on group regional plans, consistent with the June 2, 2005 *2006 Bidding Guidance for Employer/Union Direct Contract PDPs and Part C and Part D Plans Offering Employer-only Group Plans*. The relevant portion of this document is as follows:

> Risk-sharing: Part D and Regional plan A/B risk corridors will not be available for any employer-only group plans.

Section D of Attachment II in the *Advance Notice of Methodological Changes for Calendar Year 2006 MA Payment Rates,* released in HPMS on February 18, 2005, also provides guidance on risk sharing with non-group regional plans. The description of the risk sharing target in this notice is summarized below.

The risk sharing target ratio is calculated in Section V of MA Worksheet 6, based on the following formulas:

Risk sharing target ratio = Projected allowed medical expense
(Medical benefit target ratio) Projected allowed revenue

Projected allowed medical expense =
Net medical cost of Medicare-Covered services
+ Medical portion of rebatable integrated benefits

Rebatable integrated benefits = A/B Mand. Supp. benefits that reduce cost sharing
+ Other Mandatory Supplemental benefits

Projected allowed revenue = Projected allowed medical expense
+ Projected non-medical expense & Gain/loss margin in Plan A/B bid and A/B Mandatory Supplemental bid

The MAO must provide a description of the methodology that will be used to develop actual revenue and medical expense to be included in the risk sharing reconciliation. Specifically, the supporting documentation must describe the adjustment that will be made to the medical costs reported in the general ledger to account for (i) any differences in the level of cost sharing reflected in the risk sharing target for Medicare-Covered services and that required of plan enrollees, and (ii) the methodology to be used to capture expenditures for Non-Covered services that are included in the risk sharing target.

Several possible claims adjustment ratios are calculated in Section VI of MA Worksheet 6, i.e., separate ratios for Medicare-Covered services and Non-Covered services as well as a ratio for all services combined. The MAO must specify which, if any, of these ratios will be used to calculate projected allowed medical expenses.

Note that the MAO may use a different methodology to adjust medical claims reported in the general ledger that does not incorporate one of these ratios if agreed to by CMS. Also note that this documentation is required of all regional plans that are not employer-only group plans, even if the adjustment to general ledger medical claims is zero.

See Appendix B for information regarding required supporting documentation for RPPO risk sharing.

# Appendix I - BPT Technical Instructions

Technical Instructions Appendix updated as of: March 30, 2006. This appendix was prepared by the HPMS development team.

## Installation Requirements Summary

**There are six critical elements that must be configured for the BPT to work correctly. You must:**

- Create a C:\Program Files\BPT2007 folder* on your workstation
- 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.)
- Enable your Excel Standard toolbar. If you use a customized toolbar, ensure that the SAVE icon  is included. The BPT will not open properly if you do not have the SAVE icon on your toolbar.
- Set your Macro Security Settings to Medium (or Low)
- Enable Macros when you open the BPT workbook

*Note: In Windows XP Home Edition you may need to unhide your C:\Program Files directory.

### BPT Add-In

The 2007 Bid Pricing Tool (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**PBP**2007 folder. The add-in file will be saved in the C:\Program Files**BPT**2007 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 <u>overwrite</u> 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 a 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 Bid Pricing Tool (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 Bid Pricing Tool (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.

### Data Entry

All data entry fields 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.

**If you copy and paste data into the BPT, we recommend pasting using Excel’s PASTE SPECIAL feature and only paste the values into the BPT.** This will eliminate the possibility of altering cells’ predefined format through the pasting action.

**Note: Known data entry issue.**

In MA Worksheet 5 (MA Benchmark), Column G (Plan Provided ISAR factors for risk rates), the first value entered by the user (cell G39) is automatically populated in subsequent rows when new counties are added, e.g. cell G40 is incorrectly populated when a county code is added in cell B40. The user must either delete or change the value to the appropriate number.

### 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.

- If a BPT workbook is linked to another workbook (source file) and the values in this source file are changed, in order to update the BPT workbook correctly, you must:
    1. Close the source file (if open)
    2. Open the BPT workbook
    3. When prompted to update the links, click "Update"

  If needed, the source file can be re-opened at this point.

- If you update the source workbook for the following cells:
    - Plan Type (MA Worksheet 1 G7; PD Worksheet 1 I6 )
    - PD Benefit Type (PD Worksheet 1, M6)
    - Contract Number (MA Worksheet 1 D5; PD Worksheet 1 D5)
    - Use of ISAR (MA Worksheet 5 G31)

  You must perform the following steps to fully synchronize the BPT with the source data:
    1. Close the source file (if open);
    2. Open the BPT workbook, click "Update" when prompted;
    3. Click on the cell that contains the link, e.g. Contract Number
    4. Press F2
    5. Press Enter

  If needed, the source file can be re-opened at this point

### 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 message box to another location. The error message will remain open until you select another cell.
Red circles may disappear as soon as a valid value is entered into a cell. In some situations (e.g. when the validation is based on values in other cells or when you have

copied and pasted data into the BPT), you will need to reselect the Red Circle Invalid button to verify the red circles are deleted.

### Changes Not Allowed/Password Protection

You may not make changes to the structure or format of the Bid Pricing Tool worksheets. Each data item must be in its pre-defined cell location for processing by the HPMS system.

The BPT is protected through the use of passwords. **Please note that tampering with any of these passwords or unprotecting your workbook and/or worksheets will prevent you from finalizing your BPT**. You will not be able to finalize your BPT if the workbook and/or worksheets are unprotected or protected with an incorrect password. **In this situation, you will need to download a blank BPT from the HPMS and complete a new BPT**.

### 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.

Note – Consistent with Excel functionality, the undo history in the BPT is deleted when a save is performed. If your Excel 2003 settings include the Auto Recovery feature, please be aware that your undo history will also be deleted when the Auto Recovery runs. The Auto Recovery feature saves a back up of your file, therefore deleting the undo history.

### 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

Finalized Bid Pricing Tool (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.

### Printing

It is recommended that you print the BPT by using the File → Print menu option. You can also print individual worksheets by using the Print icon on the toolbar. Due to Excel limitations, we DO NOT recommend printing the entire workbook by highlighting the worksheet tabs and selecting the print icon. Following this process may cause Microsoft generated runtime errors. If this were to occur, click out of the run time error message and continue to work in your BPT. (The error will not harm your file).

### 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 the performance 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.

### Contact Us

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

# Appendix J – Red-Circle Validation Edits

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

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

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

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

**Worksheet 1**

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

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

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

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

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

**Worksheet 2**

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

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

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

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

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

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

**Worksheet 3**

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

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

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

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

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

**Worksheet 4**

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

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

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

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

**Worksheet 5**

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

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

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

**Worksheet 6**

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

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

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

Critical validations for BPT Finalization and upload:

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

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

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

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

R31, R37, R43, R45: Premiums cannot be negative.

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

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

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

**Worksheet 7**

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

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

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

**Two-Year Look-Back**

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

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

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

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

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

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

# Glossary of Terms

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

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

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

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

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

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

Covered. An abbreviation for Medicare-Covered services.

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

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

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

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

MA. An abbreviation for Medicare Advantage.

MAO. An abbreviation for Medicare Advantage Organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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