August 9, 2005

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Release of the Part D Base Beneficiary Premium, the Part D National Average Monthly Bid Amount, the Part D Regional Low-Income Premium Subsidy Amounts, and Medicare Advantage Regional Benchmarks.

In accordance section 1860D-13(a)(4) of the Social Security Act ("the Act"), we are releasing the national average Part D drug benchmark. Also in accordance with section 1858(f) of the Social Security Act, we are releasing the final MA regional benchmarks for 2006. Below we describe each benchmark. The benchmark files can be downloaded from the CMS web site at http://www.cms.hhs.gov/healthplans/rates/.

Part D Base Beneficiary Premium:
In accordance with section 1860D-13(a) of the Act, codified in 42 CFR §423.286, beneficiary premiums are calculated from the following adjustments made to the base beneficiary premium: 1) the difference between the plan's standardized bid amount and the national average monthly bid amount; 2) an increase for any supplemental premium; 3) an increase for any late enrollment penalty; 4) a decrease for Medicare Advantage Prescription Drug Plans (MA-PDs) that apply MA A/B rebates to buy down the Part D premium; and elimination or decrease with the application of the low-income premium subsidy.

The base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount. The beneficiary premium percentage ("applicable percentage") is a fraction, with the numerator of 25.5 percent; and a denominator which is 100 percent minus the total reinsurance payments that CMS estimates will be paid for the coverage year; divided by that amount plus the total payments that CMS estimates will be paid to Part D plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by both CMS and enrollees.

The Part D base beneficiary premium for 2006 is $32.20.

Part D National Average Monthly Bid Amount:
In accordance with section 1860D-13(a)(4) of the Act, codified in 42 CFR § 423.279, CMS will calculate the national average monthly bid amount, commonly referred to as the benchmark. For each coverage year CMS computes the national average monthly bid amount from approved bids submitted in order to calculate the base beneficiary premium, as provided in 42 CFR § 423.286(c).

The national average monthly bid amount is the weighted average of the standardized bid amounts for each prescription drug plan (not including fallbacks) and for each MA-PD

plan described in section 1851(a)(2)(A)(i) of the Act. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

The national average monthly bid amount is a weighted average, with the weight for each plan equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the reference month (as defined in 42 CFR §422.258(c)(1)) and the denominator equal to the total number of Part D eligible individuals enrolled in a reference month in all Part D plans except MSA plans, fallbacks, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act. For 2006, CMS assigns equal weighting to PDP sponsors (other than fallback entities) and assigns MA-PD plans included in the national average bid a weight based on prior enrollment at March 31, 2005. New MA-PD plans are assigned zero weight.

The national average monthly bid amount for 2006 is $92.30.

Note that CMS has the authority to do a geographic adjustment upon the development of an appropriate methodology to take into account differences in prices for Part D drugs among PDP regions. However, CMS cannot geographically adjust the national average monthly bid amount if it is determined that price variations among PDP regions are negligible. We reiterate our statement in the April 4, 2005 Final Payment Notice that we will not be geographically adjusting the national average monthly bid amount for 2006.

Part D Regional Low-Income Premium Subsidy Amounts:
In accordance with section 1860D-14(b) of the Act, codified in 42 CFR §423.780, full low-income subsidy individuals are entitled to a premium subsidy equal to 100 percent of the premium subsidy amount. The premium subsidy amount is equal to an amount which is the lesser of:

- the monthly Part D beneficiary premium for basic prescription drug coverage or the portion of the monthly Part D beneficiary premium attributable to basic prescription drug coverage for a Part D plan that has enhanced alternative coverage; or

- the greater of the low-income benchmark premium amount for a PDP region or the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the PDP region.

The low-income benchmark premium amount for a PDP region is a weighted average with the weight for each PDP and MA-PD plan equal to a percentage, the numerator being equal to the number of Part D eligible individuals enrolled in the plan in the reference month and the denominator equal to the total number of Part D eligible

individuals enrolled in all PDP and MA-PD plans (but not including PACE, private fee-for-service plans or 1876 cost plans)in a PDP region in the reference month.

For 2006, CMS assigns equal weighting to PDP sponsors (including fallback entities) and assigns MA-PD plans a weight based on prior enrollment (March 31, 2005). New MA-PD plans are assigned a zero weight. PACE, private fee-for-service plans and 1876 cost plans are not included.

The regional low income premium subsidy amounts are provided in a spreadsheet PartDlowincomepremiumsubsidy and is available at http://www.cms.hhs.gov/healthplans/rates/.

MA regional benchmarks:
Per section 1858(f)(2), the standardized benchmark for each MA region is a blend of two components: a statutory component consisting of the weighted average of the county capitation rates across the region; and a competitive, or plan-bid, component consisting of the weighted average of all of the standardized A/B bids for regional plans in the region. The two components are then blended, with the statutory components reflecting the market share of traditional Medicare and the plan-bid component reflecting the market share of all MA organizations in the Medicare population nationally.

- The weighting for the statutory component is based on MA eligible individuals in the region, i.e., all Medicare beneficiaries in the FFS and MA programs entitled to benefits under Part A and enrolled in Part B. (For 2006 only, ESRD beneficiaries are not included in the count of MA eligibles for the purpose of calculating the statutory component of the regional benchmark, because ESRD enrollee costs are not included in the bid for 2006.)
- The weighting for the plan-bid component consists of two steps. First, for MA organizations offering more than one regional plan in a region, a consolidated bid is calculated as an average of the bids offered in the region, weighted by projected enrollment. (That is, each R# has an average bid). Next, the regional average is calculated by applying equal weighting to the consolidated bid offered by each organization.
- For 2006, the weights applied to the statutory and plan-bid components are 87.4 and 12.6 percent, respectively.

The file is labeled MAregionalrate2006-final, and contains a weighted benchmark for most of the 26 MA regions. This file is also available at http://www.cms.hhs.gov/healthplans/rates/.

CMS will provide separate guidance to organizations that submitted MA regional plan bids for 2006 on the process for resubmitting bids that must be adjusted to reflect the final regional benchmarks.

Questions on the benchmarks can be directed to me at (410) 786-6386.

/s/
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