Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CENTERS FOR MEDICARE & MEDICAID SERVICES AUDITS OF MEDICARE PART D BIDS

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EXECUTIVE SUMMARY

OBJECTIVE

1. To assess the results of bid audits conducted by the Centers for Medicare & Medicaid Services (CMS).
2. To assess CMS's use of bid and financial audits to oversee Part D bidding.

BACKGROUND

The Medicare prescription drug program, known as Medicare Part D, provides an optional drug benefit to Medicare beneficiaries. CMS contracts with private insurance companies, known as plan sponsors, to provide prescription drug coverage for beneficiaries who choose to enroll in the program.

For a plan sponsor to offer a prescription drug plan, CMS must approve the plan sponsor's bid amount. The bid amount is the plan sponsor's per-member, per-month estimated cost of providing drug coverage. To calculate the bid amount, plan sponsors apply actuarial assumptions to base period data, which are actual data from a previous year of providing drug coverage.

Bid amounts are used to determine payments to plan sponsors. The beneficiary pays a percentage of the bid amount through premium payments. CMS pays a percentage of the bid amount through direct subsidy payments.

CMS currently uses bid audits as part of its oversight of Medicare Part D bidding. In addition, according to CMS staff, CMS intends to supplement its oversight with information gathered from financial audits. Bid audits are in-depth reviews of the actuarial assumptions used to calculate the bid amount. Financial audits verify the accuracy of plan sponsors' financial data. Although financial audits do not focus on bid amounts, they do review base period data used to determine the bid amount.

There are two types of bid audit findings: material findings and observations. Material findings are significant issues that, if corrected, would affect payments or beneficiary benefits. Observations are all other nonmaterial findings.

To assess the results of Part D bid audits, we analyzed bid audit material findings and observations from plan years 2006 and 2007. To assess CMS's use of audits to oversee Part D bidding, we reviewed CMS

guidance regarding bid audits and financial audits. To understand how CMS audits Part D bids, we conducted structured interviews with CMS staff.

FINDINGS

One-quarter of all bid audits completed for plan years 2006 and 2007 identified at least one material finding. For plan years 2006 and 2007, CMS's Office of the Actuary (OACT) completed 103 bid audits, of which 25 percent identified at least one material finding. The largest number of bid audits identified material findings involving nonpharmacy costs and methodology errors.

Any material finding could negatively affect the Part D program, whether it reveals the bid amount as potentially too high or too low. If a material finding shows that the bid amount was too high, then the Government, through its direct subsidy payments, and beneficiaries, through premium payments, would both end up paying too much for Part D coverage. On the other hand, material findings that reveal the bid amount to be too low could reduce fair competition among plan sponsors.

Bid audits are not designed to result in adjustments to bid amounts. CMS does not use bid audit findings to adjust plan sponsors' bid amounts, payments to plan sponsors, or beneficiary premiums. In addition, bid audits are not designed to lead to sanctions against plan sponsors. Instead, CMS uses bid audits to influence the submission, review, and audit of future bid amounts. According to CMS staff, using bid audits to adjust bid amounts is problematic because bid audits are completed after CMS has already signed contracts with the plan sponsors and because some of the material findings cannot be quantified. Without any penalty to plan sponsors for material findings identified in bid audits, their deterrent effect is limited.

As of April 2008, only 4 percent of the required financial audits of plan year 2006 had begun. CMS is statutorily required to complete financial audits of at least one-third of plan sponsors. However, as of April 2008, CMS had contracted for less than half and started only seven of the required number of financial audits that would review the base period data used to calculate the bid amount for plan year 2008.

Without financial audits, CMS will not be able to ensure the accuracy of the base period data used as the foundation of the bid amount. Bid audits focus on actuarial assumptions and not the accuracy of base

period data. Financial audits review the accuracy of base period data, but it is unknown when they will be completed. Delaying financial audits increases the risk that plan sponsors will use inaccurate and unsupported base period data to estimate the cost of providing Part D benefits in future plan years.

RECOMMENDATIONS

CMS should modify the bid audit process to hold plan sponsors more accountable for material findings identified in bid audits. Although CMS uses bid audits to improve future bid submissions, modifying the bid audit process could provide more effective oversight of plan sponsors' bids. To accomplish this, CMS could: (1) modify the way it responds to current bid audit findings and/or (2) modify the entire bid audit process.

CMS could modify the way it responds to current bid audit findings by developing alternative methods to hold plan sponsors accountable. In addition, CMS could modify the entire bid audit process to: (1) identify instances in which errors are misrepresentations and (2) quantify errors that affect payments to plan sponsors. Modifying the bid audit process would enable CMS to pursue stronger enforcement and corrective actions.

CMS should conduct the required number of financial audits in a timely manner. Although financial audits are not focused primarily on the bid amount, they can provide important oversight regarding the accuracy of the base period data used to calculate the bid amount. In addition, to make financial audit findings most useful, any findings related to the base period data that a plan sponsor relied upon to estimate the cost of providing Part D benefits should be provided to OACT before bid amounts are approved.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS stated that it will carefully consider our recommendation to modify the bid audit process to hold Part D sponsors more accountable for material findings. In addition, CMS agreed that it should conduct the required financial audits in a timely manner. OIG continues to recommend that CMS strengthen its oversight and enforcement approach to hold Part D sponsors accountable for their bid submissions.

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For a plan sponsor to offer a plan, CMS must approve the plan sponsor's bid submission.[3] The bid submission, which is submitted before the beginning of the plan year,[4] includes a description of the benefit package, a list of drugs on the formulary, a list of network pharmacies, and the bid amount.[5]

The Part D Bid Amount

The bid amount is the plan sponsor's per-member, per-month estimated cost of providing drug coverage.[6] Using instructions from CMS, plan sponsors calculate the bid amount using the bid-pricing tool, which is a

[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L. No. 108-173, Social Security Act, § 1860D, 42 U.S.C. § 1395w.

[2] "2008 Enrollment Information." Available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/. Accessed on April 16, 2008.

[3] 42 CFR § 423.272(b).

[4] A plan year runs from January 1 to December 31.

[5] Section 1860D-11(b) of the Social Security Act. CMS, "Solicitation for Applications for New Prescription Drug Plans (PDP) Sponsors." Available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage. Accessed on November 1, 2007.

[6] For this report, the term "bid amount" refers to the standardized bid amount, which is an estimate of the average monthly revenue that the plan sponsor needs to provide the basic benefit per beneficiary. 42 CFR § 423.265(c).

collection of spreadsheets developed by CMS.[7] Using the bid-pricing tool, plan sponsors estimate bid elements that include utilization, drug costs, and administrative fees, and the bid-pricing tool calculates the bid amount. See the Appendix for an example of the most recently approved bid-pricing tool.

Actuarial Assumptions and Bid Amounts. To estimate these bid elements, plan sponsors apply actuarial assumptions to base period data, which are actual utilization, drug cost, and administrative fee data from a previous year of providing drug coverage. Plan year 2008 was the first year in which CMS expected most plan sponsors to use base period data when determining bid amounts. Because Part D was new in 2006, CMS did not expect most plan sponsors to have experience providing similar drug coverage when estimating bid elements for plan years 2006 and 2007.[8] When a plan sponsor does not have base period data, the plan sponsor uses reasonable assumptions of utilization and costs instead.[9] As a result, most plan sponsors estimated bid elements based on assumptions alone for plan years 2006 and 2007.

When applying actuarial assumptions to base period data, a plan sponsor's actuaries must follow CMS's instructions and the Actuarial Standards of Practice (ASOP).[10] The ASOP "provide practicing actuaries with a basis for assuring that their work will conform to appropriate practices."[11] CMS instructs plan sponsors to follow applicable ASOP.[12] In particular, CMS lists the following ASOP:

- ASOP No. 5, Incurred Health and Disability Claims;
- ASOP No. 8, Regulatory Filings for Health Plan Entities;
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans;
- ASOP No. 23, Data Quality;

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[7] CMS, "Instructions for Completing the Medicare Prescription Drug Plan Bid Form for Contract Year 2006," April 2005, p. 3.

[8] Ibid.

[9] Ibid.

[10] CMS, "Instructions for Completing the Medicare Prescription Drug Plan Bid Form for Contract Year 2008," April 2007, p. 54.

[11] Actuarial Standards Board, "About the Actuarial Standards Board." Available online at http://www.actuarialstandardsboard.org/aboutasb.asp. Accessed on March 25, 2008.

[12] CMS, "Instructions for Completing the Medicare Prescription Drug Plan Bid Form for Contract Year 2008," April 2007, p. 54.

- 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; and
- ASOP No. 41, Actuarial Communications.[13]

The bid amount and bid elements must be certified by a qualified actuary who is a member of the American Academy of Actuaries.[14]

Part D Payments Based on the Bid Amounts. Bid amounts are the basis for beneficiary premiums and Government subsidies. Together, beneficiaries and CMS share the cost of the Part D benefit. Most beneficiaries are responsible for paying a monthly premium.[15] CMS, on the other hand, pays a portion of basic drug coverage for all beneficiaries through a prospective direct subsidy payment to plan sponsors.

CMS bases beneficiary premiums and direct subsidy payments on each plan's bid amount and the national average monthly bid amount. The national average monthly bid amount, calculated by CMS, is the weighted average of approved bid amounts for all plans.[16]

To calculate beneficiary premiums, CMS first sets the base beneficiary premium, which is a percentage of the national average monthly bid amount.[17] If a plan's bid amount is higher than the national average monthly bid amount, then the beneficiary's premium will be higher than the base premium by the amount of the difference. If a plan's bid amount is lower than the national average monthly bid amount, then the beneficiary's premium will be lower than the base premium by the

[13] ASOP No. 41 was added to CMS's list of applicable ASOP in its bid instructions to plan sponsors for plan year 2008.

[14] 42 CFR § 423.265(c)(3).

[15] 42 CFR § 286(e) (explaining that certain low-income beneficiaries are eligible to receive assistance to pay some or all of the premium).

[16] The approved standardized bid amounts for the following types of plans are not included in the calculation of the national average monthly bid amount: Medical savings account plans, Medicare Advantage private fee-for-service plans, special needs plans, all-inclusive care for the elderly programs under section 1894, "fallback" prescription drug plans, and plans established through reasonable cost reimbursement contracts under section 187(h) of the Social Security Act.

[17] Sections 1860D-13(a)(2) and (3) of the Social Security Act mandate base beneficiary premium is calculated. In practice, it is equal to at how the least 25.5 percent of the national average monthly bid amount.

amount of the difference. For example, if the national average monthly bid amount is equal to $100 and the base beneficiary premium is $26, then a plan with a bid amount of $90 ($10 less than the national average monthly bid amount) would have a beneficiary premium of $16.

To calculate direct subsidy payments, CMS subtracts the beneficiary premium from the plan's bid amount adjusted for the health status of the beneficiary.[18] With the health status adjustment, CMS pays more money per month for sicker beneficiaries compared to what it pays for healthier beneficiaries.

Reconciliation. As part of reconciliation, CMS finalizes the direct subsidy payments based on updated information about the health status of enrolled beneficiaries. This process begins 6 months after the close of the plan year.[19] In addition, CMS uses the finalized direct subsidy payments to determine whether risk-sharing payments are required.

Risk sharing. The MMA established risk corridors to allow the Federal Government and plan sponsors to share the profits and losses associated with providing the benefit.[20]

To determine whether risk-sharing payments are required, CMS compares the plan's "target amount" to the plan's allowable risk-corridor costs.[21] The target amount is the sum of the prospective direct subsidy payments and the beneficiary premiums, both of which are based on the bid amount, reduced by administrative costs. In general, a plan's allowable risk-corridor costs are its Part D drug costs minus direct and indirect remuneration from drug manufacturers and the reinsurance subsidy.[22] Depending on the difference between the

[18] Adjustments are made according to the health status of the beneficiary. CMS assigns a risk score to each enrolled beneficiary based on the individual's health status and demographic characteristics.

[19] 42 CFR § 423.343.

[20] MMA, P.L. No. 108-173 § 115, Social Security Act, § 1860D-15(e), 42 U.S.C. § 1395w-115(e).

[21] Allowable risk corridor costs exclude administrative costs and subtract a proportion of plan sponsors' direct and indirect remuneration. 42 CFR § 423.336(a)(1).

[22] The reinsurance subsidy covers the Federal Government's share of drug costs for beneficiaries who have reached catastrophic coverage. Within catastrophic coverage, beneficiaries contribute approximately 5-percent coinsurance toward their drug costs. Of the remaining 95 percent of drug costs, plan sponsors are responsible for approximately 15 percent and Medicare pays 80 percent. In 2006, catastrophic coverage began when a beneficiary's out-of-pocket spending reached $3,850. 42 CFR § 423.104(d)(5).

target amount and the plan's allowable risk-corridor costs, CMS may owe money to the sponsor or the sponsor may owe money to CMS.[23]

In 2006 and 2007, if a plan's allowable risk-corridor costs were at least 2.5 percent above or below the target amount, then a portion of these profits or losses were subject to risk sharing.[24] Beginning in 2008, the risk-corridor thresholds widened and plans share a portion of their profits or losses if allowable risk-corridor costs are at least 5 percent above or below the target amount.[25] This change will decrease the percentage of unexpected profits that plan sponsors will owe to CMS and increase the percentage of unexpected profits sponsors will retain. This change will also decrease the percentage of plan sponsors' losses that they are permitted to shift to CMS and increase the percentage of losses that plan sponsors will have to bear.

According to an October 2007 Office of Inspector General (OIG) report, plan sponsors owed CMS an estimated net total of $2.74 billion as a result of risk-sharing payments for plan year 2006.[26] The report concluded that the risk-sharing payments were caused by plan sponsors, in general, overestimating their bid amounts.

CMS Oversight of Plan Sponsors' Bid Amounts

Within CMS, the Office of the Actuary (OACT) is responsible for the review, approval, and audit of bid amounts. Before bid amounts are approved, OACT evaluates bid amounts using a desk review process.[27] The desk review examines bid elements for reasonableness by comparing them to the bid elements of other plan sponsors and to industry standards. According to OACT staff, OACT contracts with actuarial firms to follow up on any bid element determined to be an outlier. After reviewing documentation, actuarial contractors recommend to OACT whether it should approve the bid amount.[28]

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[23] 42 CFR § 336(c).

[24] 42 CFR § 423.336.

[25] Ibid.

[26] OIG, "Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006," OEI-02-07-00460.

[27] 42 CFR § 423.272.

[28] "CMS Bid Desk Review Manual," August 2007, p. 5.

OACT makes the final determination and contracts with approved plan sponsors in September of each year.[29]

CMS currently uses bid audits as part of its oversight of Medicare Part D bidding. In addition, according to CMS staff, CMS intends to supplement its oversight with information gathered from financial audits. Two separate offices within CMS are responsible for completing the audits. OACT is responsible for conducting bid audits of selected plan sponsors. The Office of Financial Management (OFM) is responsible for conducting financial audits. Although financial audits do not focus primarily on bid amounts, they do review base period data used to determine the bid amount.

Bid audit. After bid amounts are approved, OACT selects some plan sponsors for bid audits. These are in-depth reviews of the reasonableness of the data, range of estimates, and support for actuarial assumptions used to calculate the bid amount. They are conducted between October and February. To complete bid audits, OACT contracts with actuarial firms.

There are two types of bid audit findings: material findings and observations.[30] According to CMS's Bid Audit Procedures, material findings are findings that, if corrected, would lead to reduced payments from CMS, additional benefits to enrollees, or reduced enrollee premiums. However, according to conversations with OACT staff, in practice, a material finding is defined as a significant issue that, if corrected, would result in at least a 1-percent change in the bid amount or at least a 10-percent change in any bid element. Observations are all other nonmaterial findings. Material findings and observations may include mechanical mistakes, assumptions determined to be unreasonable, lack of supporting documentation, inaccurate reporting of expenses, and failure to follow bid instructions.

The number of plan sponsors whose bid amounts are audited by OACT may vary from year to year. OACT is not required to complete a specific number of bid audits each year. When deciding which plan sponsors to audit, OACT uses both a targeted and a random selection process.

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[29] "Solicitation for Applications for New Prescription Drug Plans (PDP) Sponsors." Available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage. Accessed on November 1, 2007.

[30] CMS, "Audit Procedures for Calendar Year 2008 Bids," p. 3.

OACT targets some plan sponsors because of issues that arose during the desk review process. Other plan sponsors are selected randomly. OACT did not audit the same plan sponsors in plan years 2006 and 2007.

After deciding which plan sponsors to audit, OACT selects a sample of plans offered by the plan sponsor. Because plan sponsors may offer more than one plan in different regions, plan sponsors may submit many different bid amounts. OACT usually selects three plans to audit from each selected plan sponsor. When selecting which plans to audit, OACT attempts to select bid amounts that cover several regions as well as basic and enhanced plans.

Financial audits. After all data for a plan year are submitted and reconciled, OFM selects plan sponsors for a financial audit. Financial audits verify that plan sponsors' reported financial data are credible and accurate. The MMA requires that a financial audit be conducted each year for one-third of all plan sponsors.[31]

Financial audits cover a wide range of topics and could reveal problems that may result in overpayment to plans, including underreporting of rebates and inaccurate claims data. In addition, financial audits compare base period data reported in the bid-pricing tool with actual data.[32]

METHODOLOGY

Scope

This study assesses the results of bid audits and the extent of CMS's use of bid audits and financial audits to oversee Part D bidding. We did not evaluate the desk review process. In addition, the study does not conduct a separate audit of bid amounts.

Data Collection

To examine material findings and observations identified in bid audits, we obtained from OACT all bid audit reports of plan sponsors conducted for plan years 2006 and 2007. After excluding 1 incomplete bid audit

[31] MMA § 112, P.L. No. 108-173 § 112, Social Security Act, § 1860D-12(b)(3)(C), 42 U.S.C. § 1395w-112(b)(3)(C).

[32] CMS, "Agreed Upon Procedures for the Financial Audit of Prescription Drug Plans, Division of Capitated Plan Audit," October 2007.

from plan year 2006 from our analysis, there were 48 and 55 bid audits completed for plan years 2006 and 2007, respectively, for a total of 103.

To understand how CMS audits Part D bids, we conducted two structured in-person interviews with CMS staff. The first interview, conducted in December 2007, was with OACT staff. Our discussion addressed specific details of the bid audit process, including the use of actuarial contractors to review bid audits, the use of bid audit findings, and possible consequences for material findings identified in a bid audit.

The second CMS interview, conducted in January 2008, was with OFM staff. Our discussion addressed specific components of the financial audits that review bid elements.

In addition, to further understand the bid audit process, we interviewed the three bid audit contractors that completed the most bid audits for plan year 2006. The interviews provided background information about the bid audit process and a description of the specific components of the bid audit, including the key principles of actuarial auditing.

Data Analysis

We counted the number of unique material findings and observations in each bid audit. A bid audit of a plan sponsor includes multiple audits of unique plans. Therefore, if the same material finding or observation applied to two or more plans reviewed by the bid audit, we counted the material finding or observation only once for the plan sponsor. To analyze the types of bid audit material findings, we grouped the unique bid audit findings into specific content categories that we developed after reviewing all material findings.

To analyze the effect of material findings on the bid amount, we reviewed the explanation of each unique material finding within a bid audit. Because material findings often only give the direction a correction would have on the bid amount (i.e., raise or lower the bid amount) as opposed to a specific amount to be corrected, we analyzed the direction of each individual material finding, not the net effect that all of the material findings in one bid audit would have on the bid amount. We also determined the number of material findings that were not quantifiable or did not report a specific direction.

To examine the bid audit process, we reviewed: (1) instructions prepared by OACT to assist the plan sponsors with the development of their bid amounts for plan years 2006, 2007, and 2008; (2) guidance prepared by OACT to assist actuarial contractors with the bid audits for

plan years 2006, 2007, and 2008; (3) guidance prepared by OACT to assist actuarial contractors with the desk review of bid amounts for plan years 2006, 2007, and 2008; and (4) relevant ASOP. In addition, we analyzed OACT staff responses to our interview questions.

To examine the financial audit process, we reviewed the guidance prepared by OFM to assist the accounting firms in their financial audits of plan sponsors for plan year 2006. CMS has not developed financial audit guidance for plan years 2007 or 2008. In addition to reviewing the financial audit guidance, we analyzed OFM staff responses to our interview questions.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

One-quarter of all bid audits completed for plan years 2006 and 2007 identified at least one material finding

For plan years 2006 and 2007, OACT completed 103 bid audits, of which 25 percent identified at least one material finding. In addition, 70 percent identified at least one observation. Overall, 76 percent of bid audits identified either a material finding or an observation.

Of the 48 bid audits completed for plan year 2006, 17 percent (8) identified at least one material finding. Seven of the eight bid audits identified only one material finding; the eighth bid audit identified four. Fifty-six percent (27) of bid audits completed for plan year 2006 identified at least one observation. The number of observations per bid audit ranged from one to seven.

Of the 55 bid audits completed for plan year 2007, 33 percent (18) identified at least one material finding. The number of material findings identified per bid audit ranged from one to five. Eighty-two percent (45) identified at least one observation. Of these, the number of observations per bid audit ranged from 1 to 11.

Table 1 below provides a breakout of the number of bid audits with and without at least one material finding or observation.

Table 1: Number of Bid Audits With and Without Material Findings and Observations by Plan Year

	Plan Year 2006	Plan Year 2007
At Least One Material Finding and No Observations	3	3
At Least One Material Finding and at Least One Observation	5	15
No Material Findings and at Least One Observation	22	30
No Findings and No Observations	18	7
Total	**48**	**55**

Source: OIG analysis of bid audits, 2008.

Between plan years 2006 and 2007, the number of bid audits with at least one material finding and at least one observation increased 200 percent, from 5 for plan year 2006 to 15 for plan year 2007. However, we cannot determine the cause of the increase. Between plan years 2006 and 2007, instructions to plan sponsors and bid audit contractors changed. As a result, we cannot determine whether:

(1) plan sponsors' bid amounts were developed with more errors or (2) the change in actuarial contractors' methods and criteria for detecting material findings or observations caused them to detect more findings.

The largest number of bid audits identified material findings involving nonpharmacy costs and methodology errors

Of the 26 bid audits from plan years 2006 and 2007 with material findings, 9 bid audits identified material findings involving nonpharmacy costs and 7 identified material findings involving methodology errors. Table 2, below, shows the number of bid audits with material findings by finding type and plan year.[33]

Table 2: Number of Bid Audits With Material Findings by Type of Finding and Plan Year

Type of Finding	Plan Year 2006	Plan Year 2007
Nonpharmacy Costs	2	7
Methodology Errors	3	4
Cost Sharing	1	4
Actuarial Certification	1	3
Risk Scores	3	1
Rebates	0	2
Pharmacy Costs	0	1

Source: OIG analysis of bid audits, 2008.

Nonpharmacy costs. Material findings regarding nonpharmacy expenses covered many areas, including the allocation of administrative costs between plans, nonpharmacy cost amounts, and the consistency of the gain/loss margin with business plans. Nonpharmacy costs as outlined in the bid-pricing tool include: marketing and sales, gain/loss,

[33] Because a bid audit may have material findings of different types, the number of bid audits with material findings in the table is higher than the number of bid audits conducted.

the net cost of private reinsurance, direct administration,[34] and indirect administration.[35]

In one bid audit completed for plan year 2006, the actuarial contractor found that the nonpharmacy expenses were unreasonably high. Specifically, the actuarial contractor stated that "insufficient attention had been given to this element of the bid, resulting in significantly higher expense levels than were reasonable for this product."

In another bid audit, completed for plan year 2007, the actuarial contractor found that gain/loss margins were inconsistent with the business plan and bid instructions. In particular, the actuarial contractor noted that "the bid sponsor did not perform any actuarial analysis to support the gain margin." The actuarial contractor also noted that the gain margin was higher than the profit target shown in the sponsor's 2006 business plan for plan year 2007 operations.

Methodology errors. Material findings involving methodology errors included calculation errors and unreasonable actuarial assumptions. For example, in one bid audit, conducted for plan year 2006, the actuarial contractor found that the plan sponsor made an error in the methodology used to project claims data. The actuarial contractor noted that correcting this error would have decreased the bid amount by 4 percent, or $8.95 per member per month.

In another bid audit, conducted for plan year 2007, the actuarial contractor found the induction factor used to estimate utilization to be unreasonable.[36] In particular, the actuarial contractor concluded that the induction effects used when calculating the bid amount were unreasonable, resulting in an incorrect assumption of utilization.

Other categories. Material findings related to cost-sharing involve the amount of cost-sharing revenue included when calculating the bid amount. For example, in one bid audit for plan year 2007, the actuarial contractor found that "the documentation of the pricing in the [Part D]

[34] Direct administration costs include functions that are directly related to the administration of the Part D plan. These functions may include customer service, billing and enrollment, and claims administration.

[35] Indirect administrative costs include functions that may be considered "corporate services," such as account operations, actuarial services, legal services, and human resources.

[36] The induction factor is the number that is used to adjust utilization to account for changes in benefit structure.

bid sheets shows that the benefit was priced with a $5 generic copay rather than $4," which the plan sponsor should have used when calculating cost-sharing revenue.

Material findings related to actuarial certifications document whether the plan sponsor's actuary followed appropriate ASOP. For example, in one bid audit, the actuarial contractor stated that it did not believe that the supporting documentation supplied by the plan sponsor was consistent with ASOP No. 31, Documentation in Health Benefit Plan Ratemaking.

Material findings involving risk scores deal with how the plan sponsor projected expected risk scores when calculating the bid amount. Risk scores are supposed to represent the health status of beneficiaries. For example, in one plan year 2006 bid audit, the actuarial contractor found that the risk score was inaccurately projected, resulting in the bid amount being too high.

Material findings involving rebates deal with how plan sponsors applied rebates to their bids. For example, in one bid audit, the actuarial contractor found that the rebates were not trended at the same rate used to trend drug costs.

The one material finding related to pharmacy costs involved the development of mail-order prescription costs. In particular, for the plan year 2007 bid audit, the actuarial contractor found that the costs of mail-order prescriptions used to calculate the bid amount were higher than the costs contracted with the mail-order pharmacy.

Regardless of whether they increase or decrease the bid amount, material findings are problematic to Medicare Part D

Regardless of whether a finding indicates that a bid amount was too high or too low, any material finding could negatively affect the Part D program.

If a material finding shows that the bid amount was too high, then the Government, through its direct subsidy payments, and beneficiaries, through premium payments, would each end up paying too much for Part D drug coverage. The Government's overpayment would be partially corrected during the reconciliation and risk-sharing processes. However, the amount recovered would depend, in part, on the category of material finding. In general, although used within the technical calculations, nonpharmacy costs are excluded during reconciliation and risk-sharing. In addition, the beneficiary's premium overpayment

would not be corrected. For plan years 2006 and 2007, 42 percent of bid audits with a material finding had at least one material finding that revealed the bid amount to be too high.[37]

On the other hand, material findings that reveal the bid amount to be too low could affect the competitive nature of the program by limiting beneficiary choice. A bid amount that is too low could result in the regional benchmark being set too low. The regional benchmark is a weighted average of plan premiums, based on bid amounts, for a given region.[38] Because the regional benchmark determines the amount of the low-income premium subsidy, if the benchmark is too low, low-income beneficiaries may not have access to the best plans available to meet their needs.[39] For plan years 2006 and 2007, 50 percent of bid audits with a material finding had at least one material finding that revealed the bid amount to be too low.[40]

Bid audits are not designed to result in adjustments to bid amounts

As of April 2008, OACT had not used bid audit findings to adjust plan sponsors' bid amounts, payments to plan sponsors, or beneficiary premiums. In addition, bid audits are not designed to lead to sanctions against plan sponsors. Instead, OACT uses material findings to make programmatic changes to the bid submission, review, and audit processes. However, without any consequences to plan sponsors for material findings identified in bid audits, their deterrent effect is limited.

According to OACT staff, adjusting bid amounts or imposing sanctions against plan sponsors as a result of bid audit material findings is problematic

According to interviews with OACT staff, using bid audits to adjust bid amounts is problematic because the audits are completed after OACT

[37] Bid audits may identify multiple material findings, which could have different effects on the bid amount. Because material findings often give only the direction a correction would have on the bid amount as opposed to a specific amount, we analyzed the direction of each individual material finding, not the net effect of all of the material findings in one bid audit.

[38] 42 CFR § 423.780(b)(2).

[39] 42 CFR § 423.780(b)(1).

[40] In addition, for plan years 2006 and 2007, some bid audits with at least one material finding had only material findings that were unquantifiable.

has already signed contracts with the plan sponsors and because some of the material findings cannot be quantified.

OACT staff assert that because of the timing of bid audits, financial recoveries cannot be based on the bid amount. Bid audits for the plan year are not completed until February, 2 months after the start of the plan year. Therefore, beneficiaries are already enrolled in plans by the time bid audits identify any material findings. Any changes in the bid amount could affect beneficiaries' premiums or benefits. However, beneficiaries could not switch plans as a result because they would not be in an open enrollment period until the next plan year. Further, changing bid amounts could affect the regional benchmark or the national average bid amount or create an uneven competitive environment among plans.

Furthermore, not all bid audits had material findings that were quantifiable. For plan years 2006 and 2007, 31 percent of bid audits with a material finding had at least one material finding that was not quantifiable. In some instances, the material finding was not quantifiable because it involved poor documentation or inadequate actuarial certifications. In other cases, the actuarial contractor may have been unable to assign a value to the error in the bid. For example, in one bid audit, the actuarial contractor could not quantify the effect of the three material findings and "rather large number" of observations identified. However, the actuarial contractor did note that "having this many irregularities in the bid development is an issue. The lack of attention to detail and diligence in handling many aspects of the bid development calls into question the accuracy of the bottom line pricing."

In addition, although plan sponsors may be sanctioned for misrepresenting or falsifying data submitted to CMS,[41] OACT staff assert that bid audits are not designed to identify whether errors are misrepresentations, making it difficult to impose sanctions on plan sponsors. In cases in which a plan sponsor falsifies or misrepresents information provided to CMS, the plan sponsor may be subject to an intermediate sanction.[42] Sanctions may include civil monetary penalties, suspension of enrollment, or suspension of payment.[43] No sanctions resulting from material findings identified in bid audits had

[41] 42 U.S.C. § 1395w-112(b)(3)(E).

[42] Ibid.

[43] Ibid.

been issued as of April 2008. According to OACT staff, there have yet to be any situations in which a referral for sanction would have been appropriate.

Bid audits influence the submission, review, and audit of future bid amounts

OACT staff assert that they use bid audit material findings to make programmatic changes, including improvements to bid submissions, for the following plan year. A review of bid submission instructions to plan sponsors shows that OACT created a new actuarial certification process for bid amounts submitted for plan year 2008. In addition, OACT changed the instructions to better inform plan sponsors as to what types of documents should be provided as supporting documentation because some initial bid audits identified instances of poor documentation.

OACT staff also stated that they use bid audit material findings in the desk review process to help target problem areas for review. Beginning with the plan year 2008 desk review process, OACT provided the reviewing actuary with a summary of the prior year's bid audit material findings. According to the desk review guide for plan year 2008, reviewers are instructed to ensure that issues identified in plan year 2007 bid audits were addressed and not repeated. In particular, the desk review guide instructs reviewers to look for supporting documentation, consider policy changes that would make an issue irrelevant, or request an explanation of how issues were addressed. Further, because a plan sponsor often uses the same methodology when calculating bid amounts for all of its plans, reviewers are instructed to examine all of a plan sponsor's bid amounts to ensure that issues were addressed, not just bid amounts for the plans that were previously audited.

OACT has also used material findings to improve the bid audit process itself. For plan year 2006, material findings revealed a problem with consistency between actuarial contracts. For plan year 2006, only four of seven contractors identified material findings in the bids they reviewed. In addition, material findings identified by one contractor accounted for half of all material findings identified.

To address the lack of consistency, CMS developed more detailed bid audit instructions for contractors for plan year 2007 and made further revisions for plan year 2008. The clarified guidance seems to have improved consistency. For plan year 2007, six of seven contractors identified material findings and the material findings were more evenly distributed among contractors.

As of April 2008, only 4 percent of the required financial audits of plan year 2006 had begun

CMS is statutorily required to conduct a financial audit of at least one-third of plan sponsors that offered a Part D plan in plan year 2006.[44] However, as of April 2008, OFM staff stated that only 4 percent of the required number of financial audits had started. Furthermore, OFM staff indicated that they have contracted for only 81 of the 165 statutorily required financial audits for plan year 2006. OFM staff did not have an estimate of when the other contracted financial audits would begin or when they would contract for the remaining audits.

Without financial audits, CMS will not be able to review the accuracy of the base period data used as the foundation of the bid amount. Bid audits focus on actuarial assumptions and not the accuracy of base period data. When reviewing base period data as part of the bid audit, actuarial contractors ensure that the base period data used to calculate the bid amount were reasonable and consistent.[45] However, according to relevant ASOP, actuaries are not required to determine whether data supplied by others is falsified or intentionally misleading, to develop additional data analysis to look for questionable or inconsistent data, or to audit the data.[46] Although the accuracy of base period data is not reviewed during a bid audit, one element of a financial audit reviews the accuracy of base period data.

Financial audits review the accuracy of base period data used to calculate the bid amount

Financial audits review the accuracy of data submitted to CMS for a given plan year. Data submitted to CMS for a given plan year become the base period data for a subsequent plan year. According to CMS staff, one element of a financial audit reviews the accuracy of base period data used to calculate a bid amount.

Starting with plan year 2008, CMS intends that financial audits will assess the accuracy of base period data used to calculate the bid amount. Base period data used to calculate the bid amount are data from the most recent, complete plan year available at the time the bid

[44] MMA, P.L. No. 108-173 § 112, Social Security Act, § 1860D-12(b)(3)(C), 42 U.S.C. § 1395w-112(b)(3)(C).

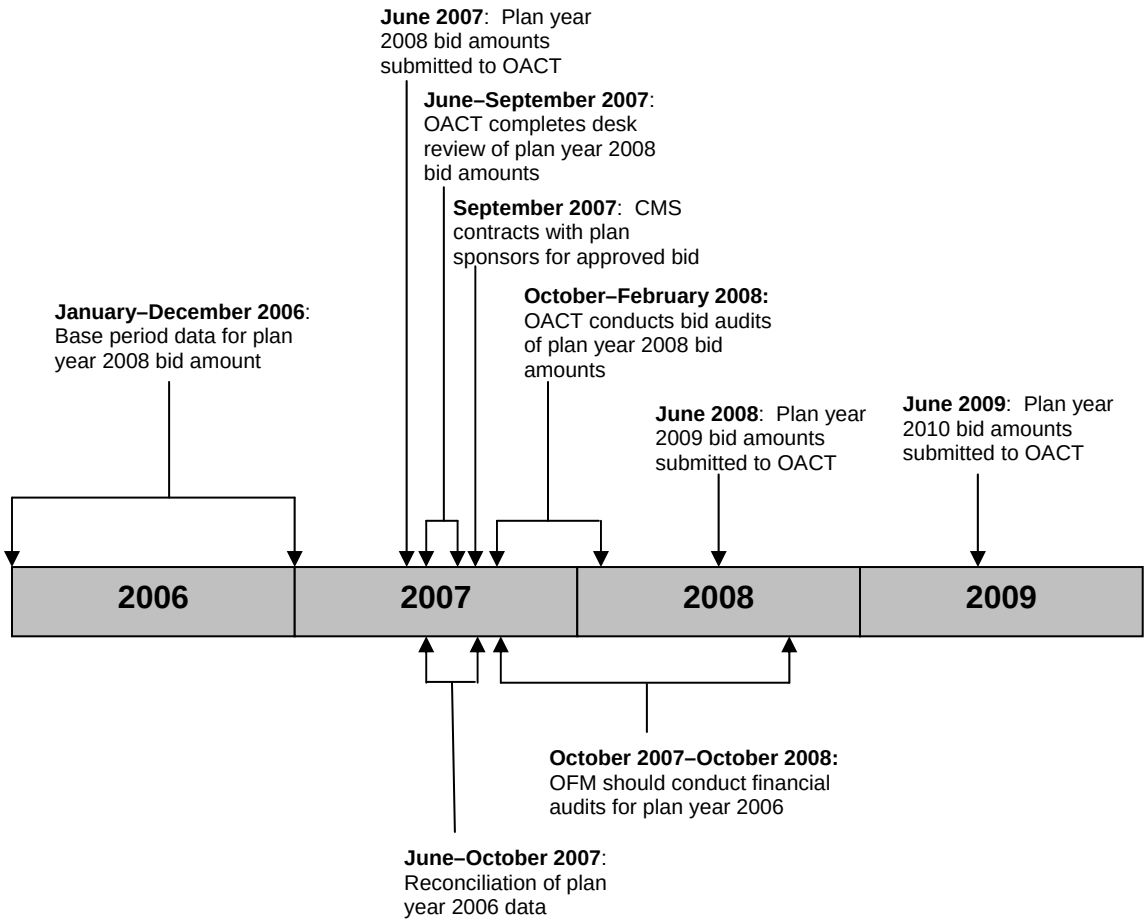
[45] CMS, "Audit Procedures for Calendar Year 2008 Bids," pp. 8–9.

[46] Actuarial Standards Board, "ASOP No. 23, Data Quality." Available online at http://www.actuarialstandardsboard.org/pdf/asops/asop023_097.pdf. Accessed on March 25, 2008.

amount is calculated. Because bid amounts are submitted to OACT 6 months before the beginning of the next plan year, base period data must come from 2 years prior. Thus, bid amounts for plan year 2008 are based on data from plan year 2006, the first full year of data available when plan sponsors submitted bid amounts in June 2007. As a result, the plan year 2006 financial audits include a review of the base period data used to calculate the plan year 2008 bid amount.

Given the timing of various aspects of the program, the earliest that financial audit findings regarding base period data could be addressed is in the next year's bid submission. For example, the earliest that plan year 2006 financial audit findings involving plan year 2008 base period data could be addressed is with the plan year 2009 bid submission. Because financial audits review data submitted by plan sponsors for a given plan year, financial audits cannot begin until final data are submitted and reconciled. Therefore, financial audits can begin only at least 6 months after the plan year—the same time bid amounts using those data are approved. Chart 1, on the next page, provides a timeline of audits of plan year 2008 bid amounts.

Chart 1. Timeline of Audits of Plan Year 2008 Bid Amounts and Base Period



Source: OIG analysis of bid audits, 2008.

Delaying financial audits increases the risk of plan sponsors repeating mistakes with their base period data in future plan years

Even accounting for the normal programmatic delay, CMS has further delayed the start of most of the plan year 2006 financial audits. When financial audits do not begin promptly, OFM's ability to identify any findings is delayed. This in turn delays plan sponsors' opportunities to correct findings and increases the risk of plan sponsors repeating the same mistakes to the detriment of beneficiaries and the program.

OFM expects the seven financial audits already started to be completed before October 2008. If the financial audits are completed before OACT approves the plan year 2009 bid amounts in September 2008, OACT

may be able to review bid amounts to ensure that financial audit findings regarding plan year 2008 base year data are not repeated in plan year 2009.

However, the remaining 158 financial audits that OFM has not begun are unlikely to be completed before September 2008. Therefore, OACT will be unable to review bid amounts to ensure that findings regarding plan year 2008 base period data are not repeated until plan year 2010 or later.

Because bid amounts are the basis for beneficiary premiums and Government subsidies, both the Federal Government and beneficiaries are affected when bid amounts are not calculated appropriately. Bid audits for plan years 2006 and 2007 identified at least one material finding for 25 percent of audited plan sponsors. However, CMS did not penalize plan sponsors for material findings identified in bid audits. In addition, as of April 2008, CMS had yet to complete financial audits to determine the accuracy of base period data used to calculate bid amounts.

To improve CMS's oversight of Part D bid amounts, we recommend that CMS:

Modify the Bid Audit Process To Hold Plan Sponsors More Accountable for Material Findings Identified in Bid Audits

Regardless of whether they increase or decrease the bid amount, material findings are problematic for beneficiaries and the program. Given limited program resources, modifying the bid audit process to not only improve future bid submissions but also hold plan sponsors more accountable for findings in the current bid could increase the effectiveness of CMS's oversight.

To accomplish this, CMS could: (1) modify the way it responds to current bid audit findings and/or (2) modify the entire bid audit process.

CMS could modify the way it responds to current bid audit findings by developing alternative methods to hold plan sponsors accountable. For example, when a bid audit identifies several material findings, CMS could require a plan sponsor, at its own expense, to have an independent, outside actuary certify the subsequent year's bid amount. CMS could also consider seeking the authority to impose sanctions against plan sponsors when material findings meet a specified threshold regardless of the reason for the material finding.

In addition, CMS could modify the entire bid audit process to: (1) identify instances in which errors are misrepresentations and (2) quantify errors that affect payments to plan sponsors. Modifying the bid audit process would enable CMS to pursue stronger enforcement and corrective actions. For example, if instances of misrepresentation are identified, CMS could refer them to its law enforcement partners for possible sanctions. For quantified errors that affect payments to plan

sponsors, CMS could consider seeking the authority to correct payments to plan sponsors at the end of the plan year.

Conduct the Required Number of Financial Audits in a Timely Manner

Although financial audits are not focused primarily on the bid amount, they provide important oversight regarding the accuracy of the base period data used to calculate the bid amount. Because CMS oversight of bid amounts is not complete without a review of the base period data's accuracy, CMS should conduct timely financial audits.

When financial audits do not begin as scheduled, OFM's identification of any findings can be delayed. This, in turn, can delay plan sponsors' opportunities to correct findings and increase the risk of plan sponsors repeating the same mistakes. For the 158 Part D financial audits OFM has yet to begin, it is unknown when plan sponsors will be able to address any potential findings, but it will most likely not be until plan years 2010 or later.

For financial audit findings related to base period data to be most useful, collaboration between OFM and OACT is important. OFM and OACT staff both acknowledged the need for collaboration regarding the use of audits as an oversight tool for Part D bidding. According to OFM staff, OFM plans to refer all base period data-related findings to OACT for followup. In addition, OACT staff plan to review OFM findings to determine how findings can be integrated into the bid submission, desk review, bid instructions, and training process. We encourage OACT and OFM to continue collaborating on financial audit findings.

In addition, OFM should strive to provide OACT with any findings related to the base period data as early as possible. In particular, OFM could provide OACT with findings relating to base period data during the desk review process. Getting findings at this time would enable OACT to evaluate the accuracy of the bid amount, in light of concerns about the base period data, before entering into a contract with plan sponsors. To provide OACT with bid-related financial audit findings during the desk review would require OFM to complete this aspect of the financial audits in the summer, prior to the completion of the full audit expected in the fall. Financial audits could be conducted in stages, with the audit of the base period data completed first.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS expressed concerns with how the bid audit findings were depicted in this report. CMS pointed out that the review was conducted on bid audits undertaken during the first 2 years of Part D. During this time, plan sponsors were attempting to navigate a complex, new program. Further, they did not have Part D data to use in developing their bids. Thus, CMS concluded that the newness of the program contributed to the number of bid audit findings. CMS also expressed concern that the report overstates the financial impact of bid audit findings. In addition, CMS provided a few technical comments. We revised language in the Background section where appropriate.

OIG does not disagree that the newness of the program may have contributed to the number of bid audit findings. However, the number of bid audit findings did not decrease in 2007 as plan sponsors became more familiar with Part D. Thus, there are likely additional factors contributing to the number of bid audit findings.

In response to CMS's other concern, that the report overestimates the financial impact of bid audit findings, the report does not estimate the financial impact of bid audit findings. In fact, the report points out that 31 percent of bid audits with a material finding had at least one material finding that was not quantifiable.

In response to our recommendations, CMS did not agree or disagree with our recommendation to modify the bid audit process to hold Part D sponsors more accountable for material findings, but stated that it will carefully consider the recommendation. CMS agreed that it should conduct the required financial audits in a timely manner.

To strengthen the bid audit process, CMS stated that it will consider using the authority it has to ensure that Part D sponsors comply with Part D operational requirements. To the extent that bid audit findings reflect a sponsor's substantial failure to comply with these requirements, CMS stated that it will consider taking compliance or enforcement actions. CMS also indicated that it would report any deliberate misrepresentations it uncovers to the appropriate authority. CMS reiterated the limitation it faces in holding plan sponsors financially accountable for material findings identified in bid audits, stating that it has no legal authority to revise bid amounts for any reason once they are accepted.

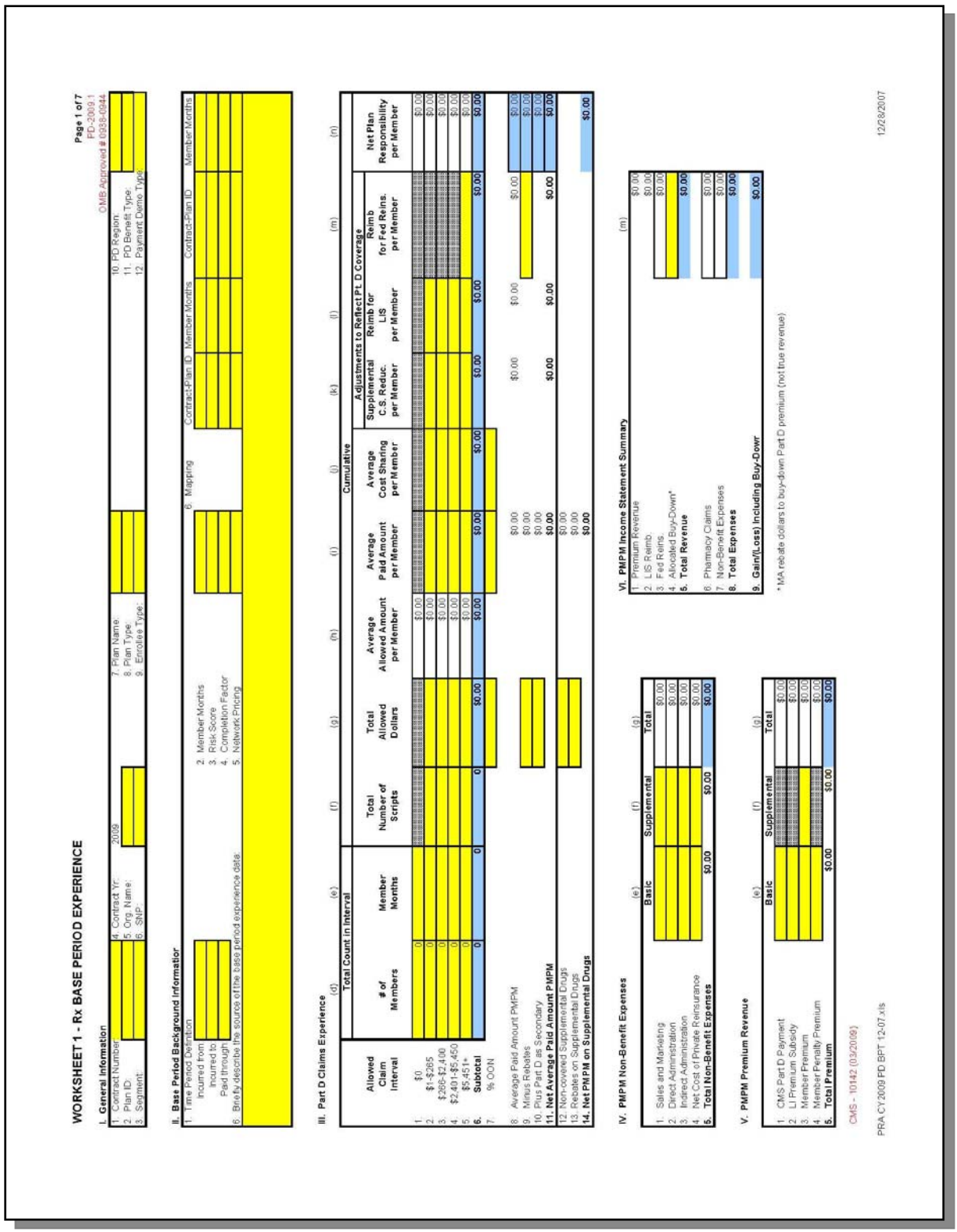
Recognizing the difficulty of holding plan sponsors accountable using the current bid audit process, OIG continues to recommend that CMS consider modifying the bid audit process to: (1) identify instances in which errors are misrepresentations and (2) quantify errors that affect payments to plan sponsors. Modifying the bid audit process would enable CMS to pursue stronger enforcement and corrective actions. CMS should also consider developing alternative methods to hold plan sponsors accountable for bid audit findings, such as sanctions. Holding plans accountable for bid audit findings that reflect noncompliance with operational requirements enhances accountability, but does not hold plan sponsors accountable for the full range of bid audit findings.

With respect to financial audits, CMS reported that funding challenges prevented it from carrying out the statutory requirement to complete financial audits on one-third of plan sponsors annually. CMS stated that it has requested sufficient funding from Congress, but Congress has not acted on those requests. Because of these continuing financial constraints, CMS stated that it is revising the audit protocols to conduct financial audits in the most efficient manner possible.

OIG continues to recommend that CMS take the steps necessary to ensure that it is meeting its statutory obligation to conduct financial audits on one-third of plan sponsors each year. In addition, for financial audit findings to be most useful, collaboration between OFM and OACT is important. OIG encourages OFM to establish a process for providing OACT with any findings related to the base period data as early as possible.

For the full text of CMS's comments, see Appendix B.

Plan Year 2009 Bid-Pricing Tool



WORKSHEET 1 - Rx BASE PERIOD EXPERIENCE

Page 1 of 7
PD-2009.1
OMB Approved # 0938-0944

I. General Information

1. Contract Number
2. Plan ID:
3. Segment:
4. Contract Yr: 2009
5. Org. Name:
6. SNP:
7. Plan Name:
8. Plan Type:
9. Enrollee Type:
10. PD Region:
11. PD Benefit Type:
12. Payment Demo Type:

II. Base Period Background Information

1. Time Period Definition
Incurred from
Incurred to
Paid through
2. Member Months
3. Risk Score
4. Completion Factor
5. Network Pricing
6. Mapping
Contract-Plan ID: Member Months: Contract-Plan ID: Member Months:
6. Briefly describe the source of the base period experience data:

III. Part D Claims Experience

Allowed Claim Interval	(d) Total Count in Interval: # of Members	(e) Member Months	(f) Total Number of Scripts	(g) Total Allowed Dollars	(h) Average Allowed Amount per Member	(i) Cumulative: Average Paid Amount per Member	(j) Cumulative: Average Cost Sharing per Member	(k) Adjustments to Reflect Pt D Coverage: Supplemental C.S. Reduc. per Member	(l) Adjustments to Reflect Pt D Coverage: Reimb for LIS per Member	(m) Adjustments to Reflect Pt D Coverage: Reimb for Fed Reins. per Member	(n) Net Plan Responsibility per Member
1. $0	0				$0.00						$0.00
2. $1-$265	0				$0.00						$0.00
3. $266-$2,400	0				$0.00						$0.00
4. $2,401-$5,450	0				$0.00						$0.00
5. $5,451+	0				$0.00						$0.00
6. Subtotal	**0**		**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
7. % OON											
8. Average Paid Amount PMPM						$0.00		$0.00	$0.00	$0.00	$0.00
9. Minus Rebates						$0.00					$0.00
10. Plus Part D as Secondary						$0.00					$0.00
11. Net Average Paid Amount PMPM						**$0.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**
12. Non-covered Supplemental Drugs						$0.00					
13. Rebates on Supplemental Drugs						$0.00					
14. Net PMPM on Supplemental Drugs						**$0.00**					**$0.00**

IV. PMPM Non-Benefit Expenses

	(e) Basic	(f) Supplemental	(g) Total
1. Sales and Marketing			$0.00
2. Direct Administration			$0.00
3. Indirect Administration			$0.00
4. Net Cost of Private Reinsurance			$0.00
5. Total Non-Benefit Expenses	**$0.00**	**$0.00**	**$0.00**

V. PMPM Premium Revenue

	(e) Basic	(f) Supplemental	(g) Total
1. CMS Part D Payment			$0.00
2. LI Premium Subsidy			$0.00
3. Member Premium			$0.00
4. Member Penalty Premium			$0.00
5. Total Premium	**$0.00**	**$0.00**	**$0.00**

VI. PMPM Income Statement Summary

	(m)
1. Premium Revenue	$0.00
2. LIS Reimb	$0.00
3. Fed Reins	$0.00
4. Allocated Buy-Down*	
5. Total Revenue	**$0.00**
6. Pharmacy Claims	$0.00
7. Non-Benefit Expenses	$0.00
8. Total Expenses	**$0.00**
9. Gain/(Loss) including Buy-Down	**$0.00**

* MA rebate dollars to buy-down Part D premium (not true revenue)

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PRA CY 2009 PD BPT 12-07.xls

12/28/2007

WORKSHEET 2 - Rx PDP PROJECTION OF ALLOWED/ NON-BENEFIT

I. General Information

1. Contract Num:	4. Contract Yr:	2009	7. Plan Name:	10. PD Region:
2. Plan ID:	5. Org. Name:		8. Plan Type:	11. PD Benefit Type:
3. Segment:	6. SNP:		9. Enrollee Type:	12. Payment Demo Type:

II. Utilization for Covered Part D Drugs

	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)
	Base Period			Components of Utilization Change						
Type of Script	# of Scripts/ 1000	Allowed per Script	PMPM Allowed	Trend in Scripts/1000	Formulary Change	Risk Change	Induced Utilization*	Other Change	Total Utilization Change	Projected Scripts/ 1000
1. Retail Generic			$0.00						0.000	0.000
2. Retail Preferred Brand			$0.00						0.000	0.000
3. Retail Non-Preferred Brand			$0.00						0.000	0.000
4. Retail Specialty			$0.00						0.000	0.000
5. Mail Order Generic			$0.00						0.000	0.000
6. Mail Order Preferred Brand			$0.00						0.000	0.000
7. Mail Order Non-Preferred Brand			$0.00						0.000	0.000
8. Mail Order Specialty			$0.00						0.000	0.000
9. Total Retail	0	$0.00	$0.00	0.000	0.000	0.000	0.000	0.000	0.000	0.000
10. Total Mail Order	0	$0.00	$0.00	0.000	0.000	0.000	0.000	0.000	0.000	0.000
11. Total Generic	0	$0.00	$0.00	0.000	0.000	0.000	0.000	0.000	0.000	0.000
12. Total Brand (Preferred and Non-Preferred	0	$0.00	$0.00	0.000	0.000	0.000	0.000	0.000	0.000	0.000
13. Total Specialty	0	$0.00	$0.00	0.000	0.000	0.000	0.000	0.000	0.000	0.000
14. Total	**0**	**$0.00**	**$0.00**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

*Adjustment to remove impact of induced utilization due to supplemental coverage

III. Cost for Covered Part D Drugs

IV. Projected Allowed PMPM

	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
	Components of Unit Cost Change					Projected Unit Cost	Projected Allowed PMPM	Manual Util/ 1000	Manual Unit Cost	Manual Rate PMPM	Credibility	Blended Allowed PMPM
	Inflation Trend	Discount Change	Formulary Change	Other Change	Tot. Unit Cost Chg							
1. Retail Generic					0.000	$0.00	$0.00			$0.00		$0.00
2. Retail Preferred Brand					0.000	$0.00	$0.00			$0.00		$0.00
3. Retail Non-Preferred Brand					0.000	$0.00	$0.00			$0.00		$0.00
4. Retail Specialty					0.000	$0.00	$0.00			$0.00		$0.00
5. Mail Order Generic					0.000	$0.00	$0.00			$0.00		$0.00
6. Mail Order Preferred Brand					0.000	$0.00	$0.00			$0.00		$0.00
7. Mail Order Non-Preferred Brand					0.000	$0.00	$0.00			$0.00		$0.00
8. Mail Order Specialty					0.000	$0.00	$0.00			$0.00		$0.00
9. Total Retail	0.000	0.000	0.000	0.000	0.000	$0.00	$0.00	0	$0.00	$0.00	0%	$0.00
10. Total Mail Order	0.000	0.000	0.000	0.000	0.000	$0.00	$0.00	0	$0.00	$0.00	0%	$0.00
11. Total Generic	0.000	0.000	0.000	0.000	0.000	$0.00	$0.00	0	$0.00	$0.00	0%	$0.00
12. Total Brand (Preferred and Non-Preferred	0.000	0.000	0.000	0.000	0.000	$0.00	$0.00	0	$0.00	$0.00	0%	$0.00
13. Total Specialty	0.000	0.000	0.000	0.000	0.000	$0.00	$0.00	0	$0.00	$0.00	0%	$0.00
14. Total	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**$0.00**	**$0.00**	**0**	**$0.00**	**$0.00**	**0%**	**$0.00**

V. PMPM Non-Benefit Expenses

	(e)	(f)	(g)	(h)	(i)	(j)
	Base Period	Trend	Contract Period	Manual Rate Expense	Credibility	Blended Expense
1. Sales and Marketing	$0.00		$0.00			$0.00
2. Direct Administration	$0.00		$0.00			$0.00
3. Indirect Administration	$0.00		$0.00			$0.00
4. Net Cost of Private Reinsurance	$0.00		$0.00			$0.00
5. Total Non-Benefit Expenses	**$0.00**		**$0.00**			**$0.00**

VI. Development of Manual Rate

1. Describe the source/year and assumptions used in the development of the manual rate.

WORKSHEET 3 - Rx CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

I. General Information

1. Contract Number:	4. Contract Yr:	2009	7. Plan Name:	10. PD Region:	
2. Plan ID:	5. Org. Name:		8. Plan Type:	11. PD Benefit Type:	
3. Segment:	6. SNP:		9. Enrollee Type:	12. Payment Demo Type:	

II. Projection Data

1. Projected Member Months:	0	2. Projected Avg Risk Score:		3. Projected LIS Member Months:	
4. Network Pricing:					

III. Part D Covered Drug Claims

	Allowed Claim Interval	(d) # of Members	(e) Member Months	(f) # of Scripts	(g) Projected Allowed	(h) Avg Amt Allowed PMPM	(i) Cost Sharing	(j) Gap PMPM	(k) PMPM Deductible	(l) Other Cost Sharing PMPM	(m) Federal Reins. PMPM	(n) Plan Liability PMPM	(o) Federal LIS PMPM
1.	$0					$0.00						$0.00	
2.	$1-$274					$0.00	$0.00					$0.00	
3.	$275-$2,509					$0.00	$0.00					$0.00	
4.	$2,510-$5,725					$0.00	$0.00					$0.00	
5.	$5,726+					$0.00	$0.00					$0.00	
6.	**Subtotal**	**0**	**0**	**0**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
7.	Minus Rebates:					$0.00					$0.00	$0.00	
8.	Minus Other Insurance:					$0.00						$0.00	
9.	Plus Part D as Secondary:					$0.00						$0.00	
10.	Projected % CON Included above:	Allowed:											
11.		Plan Liability:											
12.	**Total**				**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

IV. Non-Benefit Expenses and Gain/(Loss)

		(d)
1.	Basic Non-Benefit Expenses	$0.00
2.	Supplemental Non-Benefit Expenses	$0.00
3.	Total Non-Benefit Expenses	$0.00
4.	Basic Gain/(Loss)	$0.00
5.	Supplemental Gain/(Loss)	$0.00
6.	Total Gain/(Loss)	

V. Defined Standard Coverage Bid Development

	(i) At 0.000	(j) At 1.00
1. Claims (Allowable Cost Target):	$0.00	$0.00
2. Non-Benefit Expenses	$0.00	$0.00
3. Gain/(Loss):	$0.00	$0.00
4. Total Basic Bid	**$0.00**	**$0.00**
5. Federal Reinsurance:	$0.00	$0.00

WORKSHEET 4 - Rx STANDARD COVERAGE WITH ACTUARIALLY EQUIVALENT COST SHARING

I. General Information

1. Contract Number:	4. Contract Yr:	2009	7. Plan Name:	10. PD Region:
2. Plan ID:	5. Org. Name:		8. Plan Type:	11. PD Benefit Type
3. Segment:	6. SNP:		9. Enrollee Type:	12. Payment Demo Type

II. Projection Data

1. Projected Member months	0	2. Projected Avg Risk Score	0.000	

III. Development of Bid for Standard Coverage

	At 0.000	At 1.00
1. Claims (Allowable Cost Target)	$0.00	$0.00
2. Non-Benefit Expenses	$0.00	$0.00
3. Gain/(Loss):	$0.00	$0.00
4. Total Basic Bid	**$0.00**	**$0.00**
5. Federal Reinsurance	$0.00	$0.00
6. LIS	$0.00	

V. Std. Cov. Bid Development with Actuarially Equivalent C. S

	At 0.000	At 1.00
1. Claims (Allowable Cost Target)	$0.00	$0.00
2. Non-Benefit Expenses	$0.00	$0.00
3. Gain/(Loss):	$0.00	$0.00
4. Total Basic Bid	**$0.00**	**$0.00**
5. Federal Reinsurance	$0.00	$0.00
6. LIS		

IV: Development of Bid Components and Tests for Actuarial Equivalence

	(e) Amounts below Initial Coverage Limit <$2,510	(h) Amounts above Catastrophic Threshold >=$5,726	(k) All Amounts
1. Total Members			0
2. Member Months			0
Allowed PMPM			
3. Standard	$0.00	$0.00	$0.00
4. Standard with Act. Equiv. Cost Sharing			$0.00
5. Value of Deductible	$0.00	$0.00	$0.00
Allowed Subject to Coins.			
6. Standard	$0.00	$0.00	$0.00
7. Standard with Act. Equiv. Sharing	$0.00	$0.00	$0.00
Coins. %			
8. Standard	**25.0% A**	**0.0% C**	0.0%
9. Standard with Act. Equiv. Sharing	**0.0% B**	**0.0% D**	0.0%
Coins PMPM			
10. Standard	$0.00	$0.00	$0.00
11. Standard with Act. Equiv. Sharing	$0.00	$0.00	$0.00
Net Cost of Benefit			
12. Standard	$0.00	$0.00	$0.00
13. Standard with Act. Equiv. Sharing	$0.00	$0.00	$0.00
Rebates		For Reinsurance	Inc Reins.
14. Standard		$0.00	$0.00
15. Standard with Act. Equiv. Sharing		$0.00	

Test for Actuarial Equivalence
Effective coinsurance with alternative cost sharing = to effective coinsurance for standard cost sharing

16.	A=B	No
17.	C=D	No

WORKSHEET 5 - Rx ALTERNATIVE COVERAGE

I. General Information

1. Contract Number	4. Contract Yr:	2009	7. Plan Name:	10. PD Region:	
2. Plan ID:	5. Org. Name:		8. Plan Type:	11. PD Benefit Type:	
3. Segment:	6. SNP:		9. Enrollee Type:	12. Payment Demo Type:	

II. Projection Data

1. Projected Member months	0	2. Projected Avg Risk Score	0.000

III. Development of Bid for Standard Coverage

	At 0.000		At 1.00
1. Claims	$0.00	C	$0.00
2. Non-Benefit Expenses	$0.00		$0.00
3. Gain/(Loss)	$0.00		$0.00
4. Total Basic Bid	**$0.00**		**$0.00**
5. Federal Reinsurance	$0.00		$0.00
6. Total Coverage	**$0.00**	A	**$0.00**
7. LIS	$0.00		

V. Development of Actuarial Equivalence Test

	At 0.000		At 1.00
1. Part D Covered Drugs	$0.00	D	$0.00
2. Non-Benefit Expenses	$0.00		$0.00
3. Gain/(Loss)	$0.00		$0.00
4. Federal Reinsurance	$0.00		$0.00
5. Total Part D Covered	**$0.00**	B	**$0.00**
6. Non-Part D Covered Drugs	$0.00		
7. Total Plan Coverage	**$0.00**		
8. Total Basic Bid	**$0.00**		**$0.00**
9. LIS			

IV. Development of Bid Components

	(d)	(f)	(g)	(i)	(k)	(m)	(o)	(q)
		Part D Covered Drugs						
		Members with <$2,510	Members >=$2,510	Amounts <=ICL for all members		Amts above Catastrophic	All Members	
1. Population not Meeting Deductible		0	0	0		0	0	
2. Population Meeting Deductible		0	0	0		0	0	
3. Member Months		0	0	0		0	0	
		Type of Deductible			Type of Gap Coverage			
		Alternative Coverage ICL				Amts above	Total	Non-Part D
Allowed PMPM		Amounts below Initial Coverage Limit			Amts in Gap	Catastrophic	PMPM	Covd
4. Standard		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. Alternative		$0.00	$0.00	$0.00			$0.00	$0.00
Deductible								
6. Proposed Deductible	E							
7. Value of $275 Deductible		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
8. Value of Proposed Deductible			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Allowed Subject to Coins.								
9. Standard		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
10. Alternative		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Coins. %								
11. Standard		25.0%	25.0%	0.0%	100.0%	**0.0%** H		0.0%
12. Alternative		0.0%	0.0%	0.0%		**0.0%** I		0.0%
Coins PMPM								
13. Standard		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
14. Alternative		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Federal Reinsurance								
15. Standard						$0.00	$0.00	$0.00
16. Alternative						$0.00	$0.00	$0.00
Minus Rebates						For Reinsurance	Inc Reins.	
17. Standard						$0.00	$0.00	$0.00
18. Alternative						$0.00		
Minus Other Insurance								
19. Standard						$0.00	$0.00	$0.00
20. Alternative								
Plus Part D as Secondary								
21. Standard						$0.00	$0.00	$0.00
22. Alternative								
Net Cost of Benefit								
23. Standard		$0.00	$0.00 F	$0.00	$0.00	$0.00	$0.00	$0.00
24. Alternative		$0.00	$0.00 G	$0.00	$0.00	$0.00	$0.00	$0.00

VI. Tests for Alternative Coverage:

1. Total Coverage >= Std Coverage (B>=A)	Yes
2. Unsubsidized value>= Unsub Value for Std Covg(1=yes and D>=C)	Yes
3. Average Cost at Initial Covg Limit >= Std (G >=F)	Yes
4. Deductible <=$275 (E <=275)	Yes
5. Average Catastrophic cost sharing <= Std (I <= H)	Yes

VII. Development of Supplemental Premium:

	At 0.000
1. Part D Covered Drugs	$0.00
2. Non Part D Covered Drugs	$0.00
3. Less Basic Covered	$0.00
4. Supplemental Coverage	$0.00
5. Reduction in Reinsurance	$0.00
6. Additional Non-Benefit Expenses	$0.00
7. Additional Gain/(Loss)	$0.00
8. Supplemental Premium	$0.00

VIII. Development of Induced Utilization Adjustment

	At 0.000	At 1.00
1. Claims for Standard	$0.00	$0.00
2. Impact of Alternative Utilization on Standard		$0.00
3. Allowable Cost Target for Alternative	$0.00	$0.00
4. Induced Utilization Adjustment	0.000	0.000

WORKSHEET 6 - Rx SCRIPT PROJECTIONS FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

I. General Information

1. Contract Number	4. Contract Yr:	2009	7. Plan Name:	10. PD Region:
2. Plan ID:	5. Org. Name:		8. Plan Type:	11. PD Benefit Type:
3. Segment:	6. SNP:		9. Enrollee Type:	12. Payment Demo Type

II. Projections for Equivalence Tests

Population Not Exceeding $2,510 with Std Coverage	(f) Defined Standard Coverage		(g)	(h) Actuarially Equivalent or Alternative Benefits		(K)
All Spending	**Number of Scripts**	**Allowed $**	**Std Cost Sharing $**	**Number of Scripts**	**Allowed $**	**Cost Sharing $**
1. Retail Generic						
2. Retail Preferred Brand						
3. Retail Non-Preferred Brand						
4. Retail Specialty						
5. Mail Order Generic						
6. Mail Order Preferred Brand						
7. Mail Order Non-Preferred Brand						
8. Mail Order Specialty						
09. Total	**0**	**$0.00**	**$0.00**	**0**	**$0.00**	**$0.00**

Population Exceeding $2,510 with Std Coverage						
All Spending	**Number of Scripts**	**Allowed $**	**Std Cost Sharing $**	**Number of Scripts**	**Allowed $**	**Cost Sharing $**
10. Retail Generic						
11. Retail Preferred Brand						
12. Retail Non-Preferred Brand						
13. Retail Specialty						
14. Mail Order Generic						
15. Mail Order Preferred Brand						
16. Mail Order Non-Preferred Brand						
17. Mail Order Specialty						
18. Total	**0**	**$0.00**		**0**	**$0.00**	

Amounts Allocated Up to ICL (1)						
	Number of Scripts	**Allowed $**	**Std Cost Sharing $**	**Number of Scripts**	**Allowed $**	**Cost Sharing $ (1)**
19. Retail Generic						
20. Retail Preferred Brand						
21. Retail Non-Preferred Brand						
22. Retail Specialty						
23. Mail Order Generic						
24. Mail Order Preferred Brand						
25. Mail Order Non-Preferred Brand						
26. Mail Order Specialty						
27. Total	**0**	**$0.00**	**$0.00**	**0**	**$0.00**	**$0.00**

Amounts Allocated over Catastrophic Coverage						
	Number of Scripts	**Allowed $**	**Std Cost Sharing $**	**Number of Scripts**	**Allowed $**	**Cost Sharing $**
28. Retail Generic						
29. Retail Preferred Brand						
30. Retail Non-Preferred Brand						
31. Retail Specialty						
32. Mail Order Generic						
33. Mail Order Preferred Brand						
34. Mail Order Non-Preferred Brand						
35. Mail Order Specialty						
36. Total	**0**	**$0.00**	**$0.00**	**0**	**$0.00**	**$0.00**

	Number of Scripts	**Allowed $**	**Std Cost Sharing $**	**Number of Scripts**	**Allowed $**	**Cost Sharing $**
37. Non-Part D Covered Drugs - All Spending						

(1) - The cost sharing for the section labeled "Amounts Up to ICL" should include non-uniform deductibles and/or reduced ICL levels.

NETWORK PRICING	GENERIC		BRAND		SPECIALTY	
	% discount off AWP	Dispensing Fee	% discount off AWP	Dispensing Fee	% discount off AWP	Dispensing Fee
RETAIL						
MAIL						

WORKSHEET 7 - SUMMARY OF KEY BID ELEMENTS

I. General Information

1. Contract Number:	4. Contract Yr: 2009	7. Plan Name:	10. PD Region:
2. Plan ID:	5. Org. Name:	8. Plan Type:	11. PD Benefit Type:
3. Segment:	6. SNP:	9. Enrollee Type:	12. Payment Demo Type:

II. 2009 Defined Standard Benefit Parameters

1. Deductible	$275
2. Initial Coverage Limit	$2,510
3. Out-of-pocket Limit	$4,050

III. Summary of Key Bid Elements

1. Standardized Part D Bid	$0.00
2. National Average Monthly Bid Amount	
3. Base Beneficiary Premium	
Basic Part D Premium (prior to A/B rebate allocation)	
4. Unrounded	$0.00
5. Rounded	$0.00
Supplemental Part D Premium (prior to A/B rebate allocation)	
6. Unrounded	$0.00
7. Rounded	$0.00
8. Prospective Federal Reinsurance (non-standardized)	$0.00
9. Prospective Low-income cost sharing subsidy (non-standardized)	$0.00
10. Target amount adjustment (allowed costs as a ratio of bid)	1.0000
Rounding Rule	
11. Round Part D premiums to nearest	$0.10

IV. Part D Bid Pricing Tool Contacts

Plan Bid Contact	
Name	
Phone	
Email	
Part D Certifying Actuary	
Name and Credentials	
Phone	
Email	
Part D Additional BPT Contact	
Name	
Phone	
Email	
Date Prepared	

APPENDIX ~ B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 26 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Centers for Medicare & Medicaid Services Audits of Medicare Part D Bids" (OEI-05-07-00560)

Thank you for the opportunity to comment on the draft report entitled, "Centers for Medicare & Medicaid Services Audits of Medicare Part D Bids" (OEI-05-07-00560). While we feel that the Centers for Medicare & Medicaid Services (CMS) and OIG staff have worked collaboratively on this report, we want to share the following comments and concerns related to the depiction of CMS' audits of the Medicare Part D bids.

As we noted during your review, CMS repeatedly requested sufficient funding to perform its program oversight, including Part D audits. Congress has not acted on those requests. As a result, CMS had to redirect funds from other competing priorities which has led to a delay in conducting those audits.

In addition, the bid audits studied were from 2006 and 2007, the first two years of the Part D program. As has been noted before, Part D was a new and innovative program and there were many unknown factors in a program of this magnitude. Further, as the report notes, prior to the 2008 bidding cycle plans did not have actual program data which they could use to develop their bids. We expect that the newness of the program contributed to the number of bid audit findings for these years.

We also have concerns that the report overstates the financial impact of the bid audit findings on the Part D program. A relatively low threshold was used in defining a material finding--specifically, an issue that, if corrected, would result in at least a 1 percent change in the bid amount. Moreover, the report indicates that 75 percent of the completed bid audits identified no material findings. However, we would like to note that although the financial consequences of the deficiencies identified through the Part D bid audit process cannot be measured using available data, the overall impact is probably not large. For example, of the 40 audit findings for the 2006 bids that, if corrected, would result in a change to the bid, roughly half would have resulted in a bid increase and the other half a bid decrease.

We believe that the Part D bid audit process, as established, practiced, and refined to date, has been appropriate, reasonable, and effective. Our detailed comments on the audit report follow.

OIG Recommendation

To improve CMS' oversight of Part D bid amounts, OIG recommends that CMS modify the bid audit process to hold plan sponsors more accountable for material findings identified in the bid audits.

CMS Response

We will carefully consider your recommendation that CMS modify the bid audit process to hold Part D sponsors more accountable for material findings. The report itself recognizes the limitations in holding Part D sponsors financially accountable for bid findings identified through the bid audit process. CMS performs a comprehensive review of each Part D bid before it is accepted. Once the bid accepted and used to set plan premiums and payment levels, there is no legal authority to revise the accepted bid amount for any purpose, including adjusting plan payments. However, CMS does have the authority to ensure Part D sponsors' compliance with the operational requirements of the Part D program. To the extent that bid audit findings reflect a sponsor's substantial failure to comply with program requirements, including those related to annual bid submissions, CMS will consider taking compliance (e.g., request corrective action plan) or enforcement (e.g., sanctions or contract termination) actions against those sponsors. Finally, if CMS uncovers deliberate misrepresentations or fraud during the bid audits, we will report such findings to the appropriate authority.

OIG Recommendation

To improve CMS' oversight of Part D bid amounts, OIG recommends that CMS conduct the required number of financial audits in a timely manner.

CMS Response

We agree that CMS should conduct the required financial audits in a timely manner. However, the OIG report fails to represent the funding challenges CMS faced in carrying out the statutory one third financial audit requirements. We believe it is important to note that CMS made a request for funds in fiscal year (FY) 2007 and FY 2008 and that in each year Congress failed to enact our budget request. This request would allow us to fully fund the required audits. Nevertheless, CMS has taken measures to achieve timelier audit results with the funding levels available. We are revising the audit protocols for the remaining FY 2006 audits to perform them in the most efficient manner possible. We are eagerly awaiting our audit results. We fully expect that this information will prove helpful and will form the basis for future revisions to the financial audit protocol process.

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas Komaniecki, Deputy Regional Inspector General.

Suzanne Bailey served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Tina Sacks; other central office staff who contributed include Cynthia Thomas.