November 2024 Actuarial User Group Call

Thursday, November 14, 2024
11:00AM - 12:00PM ET

To be able to ask questions during the call, join online at—

- https://cms.zoomgov.com/s/1602253471
- Meeting ID: 160 225 3471
- Passcode: 372081

To participate in listen-only mode, join by phone at—

- Participant Dial-In Number: (833) 568-8864 US Toll Free
- Meeting ID: 160 225 3471
- Passcode: 470654

- Welcome
  - Reminder that an agenda for this call has been posted to the CMS webpage at:

    https://www.cms.gov > Medicare > Payment > Medicare Advantage Rates & Statistics > Actuarial Bid Questions
  - We have also posted mockups of the draft CY2026 MA and Part D Bid Pricing Tools (BPTs). It may be helpful to have these files open during the call.

- CY2025 Bid Review: Lessons Learned
  - We appreciate all the feedback we received during the industry comment period. We have shared pertinent comments with other areas within CMS and are taking the comments into consideration when developing the CY2026 BPTs and Bid Instructions.
  - We have noticed that submitted Appendix B documentation items do not always clearly tie to amounts in the MA and/or PD BPT.
    - Due to this, reviewers often must ask for documentation showing how an Appendix B item ties to amounts in the MA and/or PD BPT. In answering these questions, plan sponsors often simply add a column to the submitted item to show how it ties to the amounts in the MA and/or PD BPT.
    - We would prefer plan sponsors include a column that ties the Appendix B documentation item to the MA and/or PD BPT with the initial submission.
  - We have noticed instances where it is difficult to get a response from the plan sponsor when the Plan Bid Contact, the Certifying Actuary, and the Additional BPT Actuarial Contact listed on MA WS6 and PD WS7 are not three different people. Given this, we would prefer plan sponsors to include three different contacts in the BPT on MA WS6 and PD WS7.
  - We have noticed that actuaries often request significant changes to the initial assumptions and projections used to develop the BPT after the initial actuarial certification has been submitted.
    - In the initial actuarial certification, the actuary is attesting to the reasonableness of the initial assumptions and projections used to develop the BPT.

        - As such, once the initial actuarial certification has been submitted, there is no flexibility for the plan sponsor or actuary to request changes to the initial assumptions and projections used to develop the BPT.
        - In cases where an error is discovered during the actuary's review for initial certification, the certifying actuary must contact OACT at BidReviewC@cms.hhs.gov to correct the issue at that time rather than qualifying the initial certification.
        - For plans that wish to print their actuarial certification, use CTRL + P while on that page within HPMS.
    - Bidders Training
        - We previously solicited feedback on whether to maintain the online bidders training. We plan to continue to provide this training and update the sessions as needed.
        - We are soliciting additional feedback on whether there are additional topics to be added to the current bidders training.
    - Medicare Prescription Payment Plan (M3P)
        - Plans need to provide detailed quantitative and qualitative support of the development of the M3P values in the non-benefit expense buildup. Best practice is to show the development of assumptions for both the frequency and severity of the M3P Bad Debt amount.
        - The application of the M3P projection in the BPT should match the development of the assumption. For example, if the development assumed greater M3P utilization for non-LI members, then a bid with higher non-LI membership should have a greater M3P amount than a bid with lower non-LI membership.
        - Given the uncertainty around this program, we encourage plans to evaluate emerging CY2025 experience and adjust projections accordingly.
    - Formulary Reference File (FRF) Primer
        - During the industry comment period, we received a few requests to better understand the timeline of the FRF, given its impact on OOPC/TBC calculations. Joining us on this call are staff from the Division of Formulary and Benefit Operations to provide an overview of the FRF process and timeline.
    - To help us respond in a timely manner to feedback that involves other areas of CMS, we remind you to please copy the appropriate resource mailboxes in addition to any emails sent to the actuarial-bids mailbox. These email addresses can always be found in the introductory note within the UGC Q&A file, and a few are noted here.
        - For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
        - For Part D policy-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
        - For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
        - For risk adjustment topics: riskadjustmentoperations@cms.hhs.gov and riskadjustmentpolicy@cms.hhs.gov

- CY2026 Bid Pricing Tools (BPTs)
    - Reminder: List of draft BPT changes is included in the posted agenda. An updated mockup of the draft CY2026 MA and Part D BPTs have also been posted at the same link.
    - Reminder that the mock-ups do not contain updated benefit parameters/ratebook for CY2026 and do not contain working macros.
    - We are proposing discontinuing the ESRD-SNP BPT due to the change in the ESRD definition for CY2026 to Chronic Kidney Disease (CKD) with two categories—(i) CKD requiring dialysis/ESRD; and (ii) CKD not requiring dialysis. All C-SNPs that target CKD will now be required to submit a MA BPT.
        - The instructions for pricing the MA BPT will not change (that is, all information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status for the time period that enrollees are in that status—with the exception of Worksheet 1, Section V; Worksheet 4, Section III; and Worksheet 5, Section VIII). See more details on this in the instructions section of this agenda.
    - Proposed Changes to MA BPT:
        - We are proposing the removal of VBID-H indicator on Worksheet 1 Section I and line 19c from mapping section of Worksheet 3.
        - We are proposing adding a cell to Worksheet 1 of the MA BPT to reflect the certifying actuary's chosen MA level of significance when determining what base period data to include for crosswalked plans in the MA BPT. See cell I17 on Worksheet 1 of the MA BPT.
        - We are proposing to add entries to reflect the break-out of the net PMPM for risk-sharing arrangement payment adjustments in both the base and projection period. See new Section VI on Worksheet 1 and cells U78:U98 on Worksheet 4. See more details in the instructions section of this agenda.
        - We are proposing requiring all C-SNPs that target CKD to complete MA Worksheet 4, Section III. Since all C-SNP that target CKD are now required to complete this section, we intend to add a cell to MA Worksheet 4, Section III indicating whether the plan wants the Total CY ESRD "subsidy" in cell J130 to flow through to MA Worksheet 4, Section II cell H95. This new yes/no indicator is in cell J131 on MA Worksheet 4. See more details in the instructions section of this agenda.
    - Proposed Changes to Part D BPT:
        - We are proposing removing insulins and vaccine lines from Section VI on Worksheet 1. We intend to only collect information for Maximum Fair Price/Negotiated Drugs in this section. For CY2026, this would remain grayed out since it is not applicable for CY2024.
        - Like the new risk-sharing cells in the MA BPT, we are proposing adding cells to the PD BPT to reflect the dollars associated with DIR #10 in the base and projected period. See new section VIII on Worksheet 1 and Worksheet 2.
        - We are activating cells on Worksheet 2 for Maximum Fair Price Drugs projection factors.
            - Refer to instructions section later in agenda for specifics on how to fill out these cells. We are soliciting feedback on proposed instructions for these cells.

        - We are activating Maximum Fair Price Drug inputs on Worksheet 3 Section IV and propose removing the insulins and vaccines lines from this section.
            - Refer to instructions section later in agenda for specifics on how to fill out these cells.
        - We are activating and relocating inputs on Worksheet 6 for Subsidy for Selected Drugs. See cells D59:D60 on Worksheet 6. These cells will flow through to the payment summary on Worksheet 7 cell F31. See more details in the instructions section of this agenda.

- CY2026 Bid Pricing Instructions
    - Detailed instructions changes can be seen in Appendix 1 of this agenda.
    - Risk-Sharing Arrangements
        - We are interested in the magnitude of risk-sharing arrangement payment adjustments and DIR #10 in the base and projection periods and how these amounts affect the MA and PD bid.
        - To address this, we intend to add entries to the MA BPT to reflect the break-out of these adjustments by service category in both the base and projection periods. Similarly, we intend to add cells to the PD BPT to reflect the break-out of the dollars associated with DIR #10 in the base and projection periods.
        - These cells are stand alone and do not feed into the rest of the BPT. As such, risk-sharing arrangement payment adjustments should continue to be reported in the allowed and net PMPM cells in the MA BPT. Similarly, DIR #10 should continue to be reported in the rebates cells in the PD BPT.
    - ESRD
        - We intend to remove Appendix I, due to the proposal to discontinue the ESRD-SNP BPT. All C-SNPs that target CKD will be required to submit a MA BPT.
        - C-SNPs that target CKD will be required to project at least one non-ESRD status member month to develop a valid MA BPT. We do not intend to add guidance to the instructions for this situation. If an ESRD-SNP has no experience with non-ESRD status enrollees, we would expect the plan to develop a manual rate using normal procedures. Please feel free to reach out to the actuarial-bids mailbox if additional guidance is needed.
        - We intend to clarify that an enrollee is in ESRD status for a specified time period if the beneficiary is identified as ESRD in the “Monthly Membership Report” (MMR).
        - We intend to add language indicating that MA Worksheet 4 Section III must be completed by all C-SNPs that target CKD. Since all C-SNPs that target CKD are now required to complete this section, we intend to add a new cell on MA Worksheet 4 Section III (cell J131) to indicate whether the plan is electing to have the Total CY ESRD “subsidy” flow through to MA Worksheet 4 Section II.
        - Due to the changes to ESRD, we intend to update Appendix B item 24 in the MA Instructions to include additional items.

- Gain/Loss Margin
    - We intend to update Appendix B item 8.6 in the MA and PD Instructions to require this item to be completed when gain/loss margin as a percentage of revenue at the bid level is less than –10 percent and the bid has existed since CY2022.
- VBID Hospice
    - We intend to remove references to the VBID-H indicator from the MA Instructions due to the proposal to remove this cell from the CY2026 BPT.
    - We intend to remove PBP line 19c in Appendix F from the MA Instructions due to the proposal to remove this cell from the CY2026 BPT.
    - Since plans were still able to offer VBID Hospice during CY2024, references for how to reflect VBID Hospice experience in the base period will not be removed from the MA Instructions.
- Level of Significance
    - We intend to add an entry for the MA level of significance in Worksheet 1 Section II. If an MA level of significance is used to determine whether a Contract-Plan ID-Segment ID is listed in Worksheet 1 Section II, line 6, plans must enter the MA level of significance in this cell.
- Supporting Documentation
    - We intend to add a bullet to the general section of Appendix B in the MA and PD Instructions stating that supporting documentation items with data that cannot be directly traced back to data entered in the BPT are not acceptable.
    - We intend to update Appendix B item 6 in the MA Instructions to clarify justification must be included if the PMPM impact of the maximum OOP is zero.
    - We intend to update Appendix B item 22.1 in the MA Instructions to clarify that this is a separate item than the item that is uploaded to HPMS via the Cost Sharing Justification link.
        - Appendix B item 22.1 applies to (i) MA plans that use a coinsurance for inpatient hospital acute and psychiatric or SNF plan benefits; (ii) MA plans that use a copayment for DME service categories for which CMS does not have a set copayment limit; and (iii) MA plans that use a coinsurance or copayment amount for other service categories for which CMS does not have an established limit on cost sharing under §§ 422.100 or 422.113.
    - We intend to update Appendix B item 23 in the MA Instructions to clarify this item must be included for all types of capitation arrangements—not just global capitation arrangements.
- Appendix E – Rebate Reallocation Guidelines
    - We appreciate all the feedback for rebate reallocation we received during the industry comment period. We will not be making any changes in our guidance for CY2026, but we will be clarifying situations where we received multiple inquiries.
    - We are reviewing scenarios where plans had a negative Part D basic premium to determine if additional clarifications or updates are needed to our guidance.

- Other Part D Instruction Changes
  - Instructions will be added for the activated maximum fair price drug cells on Worksheet 2 and 3.
  - For the new Subsidy for Selected Drugs cells on Worksheet 6, instructions will be added, as well as a supporting documentation requirement in Appendix B item 6.7.
  - We intend to clarify in the Clarifications section of Worksheet 6 bid instructions, that scripts and dollars for claims that straddle multiple benefit phases must be prorated and allocated to the appropriate benefit phases.
  - We intend to add a supporting documentation requirement in Appendix B item 12.5 to clarify that Part D manual rate support should include member months, allowable costs, and scripts by benefit phase.
  - Please see Appendix 1 for more details.
- Please submit comments regarding these proposed **BPT and bid instruction** topics by 9:00 AM Pacific Standard Time on **December 2, 2024** to: actuarial-bids@cms.hhs.gov

- Other Bidding Topics/Announcements
  - Bid Improvement Initiative Program
    - OACT is seeing continuous improvement in the bids being submitted.
    - Outreach is complete.
    - If you have heard from us, we ask that you take the feedback constructively to address our concerns in the next bid submission.
    - If you did not hear from us, please continue to evaluate your supporting documentation and peer review process and make improvements where possible.
  - The Cumulative User Group Call Q&A File has been updated with questions and answers from CY2007 to CY2025 and can be found at: https://www.cms.gov > Medicare > Payment > Medicare Advantage Rates & Statistics > Actuarial Bid Questions

- Live Q&A

- Conclusion

Appendix 1
Proposed Changes to the CY2026 Bid Instructions

Medicare Advantage (MA)

II. PRICING CONSIDERATIONS

End-Stage Renal Disease (ESRD)

All information provided on Worksheets 1 through 7 must exclude the experience for enrollees in ESRD status, for the time period that enrollees are in that status, with the exception of Worksheet 1, Section V; Worksheet 4, Section III; and Worksheet 5, Section VIII.

An enrollee is considered to be in ESRD status for a specified time period if the enrollee is identified as ESRD in the "Monthly Membership Report" (MMR).

Worksheet 4, Section III must be completed for all C-SNPs that target Chronic Kidney Disease (CKD). Other plan types may complete Worksheet 4, Section III, but are not required to. If Worksheet 4, Section III is completed, plans must elect whether to reflect the Total CY ESRD "subsidy" in Worksheet 4, Section II using the "Include ESRD "subsidy" in Total Revenue Requirement" cell on Worksheet 4, Section III.

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III. DATA ENTRY AND FORMULAS

MA WORKSHEET 1 – MA BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

SECTION II – BASE PERIOD BACKGROUND INFORMATION

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Line 5 – Level of Significance

If a level of significance is used to determine whether a Contract-Plan ID-Segment ID is listed in Worksheet 1, Section II, line 6, enter the level of significance in this cell. The value must be greater than 0% and less than 100%. Otherwise, leave this cell blank.

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SECTION VI – BASE PERIOD RISK-SHARING PAYMENT ADJUSTMENTS

Section VI summarizes the base period risk-sharing arrangement payment adjustments net PMPM amount by service category.

In lines a through q:

- ✓ **Column v – Net PMPM**

  Enter the net PMPM for base period risk-sharing arrangement payment adjustments by service category. The amount entered in this column is a subset of that entered in Section III, column d, and may be positive or negative depending on the direction of the payment. For example, if the payment was made from the plan sponsor to the provider the amount would be positive, whereas if the payment was made from the provider to the plan sponsor the amount would be negative. Do not include salaries, fee-for-service payments, capitations, or returned withholds in column v.

Line r – COB/Subrogation (outside claims system):

- ✓ **Column v – Net PMPM**

  Line r is set equal to zero.

MA WORKSHEET 4 – MA PROJECTED REVENUE REQUIREMENT PMPM

SECTION II – DEVELOPMENT OF PROJECTED REVENUE REQUIREMENT

SUBSECTION C – All Beneficiaries (Total of Subsections A and B)

In lines a through q and t:

…

- ✓ **Column u – Net PMPM for Projected Risk-Sharing Payment Adjustments**

  Enter the net PMPM for projected risk-sharing arrangement payment adjustments by service category for the total benefits. The amount entered in this column is a subset of the automatically calculated amounts in Section II, Subsection C, column h, and may be positive or negative depending on the direction of the payment. For example, if the payment was made from the plan sponsor to the provider the amount would be positive, whereas if the payment was made from the provider to the plan sponsor the amount would be negative. Do not include salaries, fee-for-service payments, capitations, or returned withholds in column u. Line t is set equal to zero.

Line r – ESRD

This line is populated based on Section III (except line r, column u, which is set equal to zero).

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

Section III allows for an adjustment to A/B mandatory supplemental benefits in line r of Section II. This adjustment is split into two sections: one for basic benefits and the other for supplemental benefits. Values entered in input cells must be greater than or equal to zero.

Section III must be completed for all C-SNPs that target CKD. Other plan types may complete Worksheet 4, Section III, but are not required to.

…

Include ESRD "subsidy" in Total Revenue Requirement

Enter "Y" if the plan is electing to reflect the Total CY ESRD "subsidy" in line r of Section II. Enter "N" if the plan is not electing to reflect the Total CY ESRD "subsidy" in line r of Section II.

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APPENDIX B – SUPPORTING DOCUMENTATION
General

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Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- …
- Excel spreadsheets with data that cannot be directly traced back to data entered in the BPT

6. A detailed description of the process used for adjusting cost sharing due to maximum OOP limits, including how the PMPM impact of the maximum OOP was determined. (Worksheet 3). Note that if the PMPM impact of the maximum OOP is zero, a justification must be included.

8.6. Justification of benefit value in relation to the gain/loss margin, if the gain/loss margin as a percentage of revenue at the bid level is greater than 11.5 percent, or if the gain/loss margin as a percentage of revenue at the bid level is less than –10% percent and the bid has existed since CY2022. The required elements include—

8.6.1. A comparison of premiums for CY2026 and CY2025, if applicable. Include the rounded MA premium, Part D basic premium after MA rebates, Part D supplemental premium after MA rebates, total plan premium, and MA rebate allocation for the Part B premium.

8.6.2. Support for changes in A/B mandatory supplemental benefits, if applicable. Provide a comparison in an Excel spreadsheet of (i) data from Worksheet 4, Section IIC, column R, lines a through u in the BPT, and (ii) the best estimate of the same items changing only the A/B mandatory supplemental benefits to be identical to CY2025.

22. Support for the development of projected cost sharing (Worksheet 3). The required elements include—

22.1. A detailed demonstration of how coinsurance or copayments, for which CMS does not have an established amount, satisfy CMS service category requirements. This demonstration must be included when:

a. A coinsurance is used for inpatient hospital acute and psychiatric or SNF plan benefits;

b. A copayment is used for DME service categories for which CMS does not have a set copayment limit;

c. A coinsurance or copayment amount is used for other service categories for which CMS does not have an established limit on cost sharing under §§ 422.100 or 422.113.

23. Support for capitation arrangements or risk-sharing arrangements. The required elements include—

23.1. A description of the arrangement.

23.2. A demonstration of the methodology used to allocate the impact of the arrangement to BPT service categories (including the allocation to the MA and Part D BPTs, if the arrangement applies to Part D services)

24. Support for the "Development of the Projected Contract Year ESRD 'Subsidy'" (Worksheet 4). This required documentation includes the following:

24.1. Base period (for example, 2024) revenues and medical expenditures for Medicare covered benefits provided to enrollees in ESRD status.

24.2. The source for, and the development process of, any manual rates used.

24.3. Relevant base-to-contract year trend factors.

24.4. A demonstration of the revenue development, including the development of risk scores, split by dialysis, transplant and functioning graft.

24.5. A statement of the credibility approach used—for example, the CMS guidelines.

24.6. A description of the credibility methodology used if it varies from the CMS guidelines.

24.7. Each support item listed above must be split between dialysis claims and all other claims.

Part D (PD)

PD BPT Worksheet 1

Section VIII – DIR #10 Experience

Section VIII summarizes the DIR #10 (Risk-Sharing Arrangement Payments and Adjustments) dollars for the base period.

Line 1, column k

Enter the total dollars for DIR #10 for the base period. Experience in this section is a subset of that entered in Section III, line 7, column g, and may be positive or negative depending on the direction of the payment. For example, if the payment was made from the plan sponsor to the provider the amount would be negative, whereas if the payment was made from the provider to the plan sponsor the amount would be positive.

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Worksheet 2

Section II – Utilization for Covered Part D Drugs

Lines 1 through 9 – Base Period

- ✓ **Column e – Number of Scripts/1000**

  Enter for each line the number of prescriptions that were filled in the base period, expressed as annual prescriptions per 1,000 members, by point-of-sale (retail or mail order as defined by the PBP) and type of drug (generic, preferred brand, non-preferred brand or Specialty). The Maximum Fair Price Drugs are defined as those drugs which were selected for negotiation for initial price applicability for CY2026. Do not include the number of scripts/1000 for the Maximum Fair Price Drugs in rows 1-8.

- ✓ **Column f – Allowed per Script**

  Enter the average allowed amount per script by type of script filled in the base period for each line. The term "allowed amount" is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable, plus the vaccine administration fee, prior to the application of any rebates recovered after the point-of-sale.

- ✓ **Column g – PMPM Allowed**

  The value is calculated automatically in the BPT as column e times column f divided by 12,000 for each line.

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Section VIII – DIR #10 Projection

Section VIII summarizes the DIR #10 (Risk-Sharing Arrangement Payments and Adjustments) PMPM for the projection period.

Line 1, column n

Enter the PMPM for DIR #10 for the projection period. This entry should be based on the plan benefit. For defined standard plans, this amount should be based on the defined standard benefit. For alternative benefit plans, the amount should be based on the alternative benefit. The amount entered in this section is a subset of the total rebate amount entered elsewhere in the BPT, and may be positive or negative depending on the direction of the payment. For example, if the payment was made from the plan sponsor to the provider the amount would be negative, whereas if the payment was made from the provider to the plan sponsor the amount would be positive.

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WORKSHEET 3

Line 1, columns d through f – Maximum Fair Price Drugs

Enter all projection period experience for the selected drugs that were negotiated for initial price applicability for CY2026.

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WORKSHEET 6

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid. Part D sponsors must model the impact of the alternative benefit compared to the DS by making adjustments in utilization and average script pricing in Worksheet 6. The distributions must be based on the intervals defined for DS coverage. For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 10 must reflect the utilization for the AE, BA or EA plan for members expected to have allowed costs less than or equal to the catastrophic threshold. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.

For claims which straddle multiple coverage phases, the script count and dollars must be prorated and allocated into the appropriate phases.

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SUBSIDY FOR SELECTED DRUGS

Enter the projected estimate for the selected drugs subsidy for defined standard, actuarially equivalent or alternative coverage.

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APPENDIX B – SUPPORTING DOCUMENTATION

6. A quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories used in pricing (Worksheets 2, 6). The required elements include—
   - 6.1. The PBP description of the deductible and copay/coinsurance structure by days supply, point-of-sale and claims interval.
   - 6.2. Allowed costs, effective cost sharing and script counts by formulary tier within each claims interval based on the cost sharing structure specified in the PBP, including days supply and point-of-sale.
   - 6.3. A quantitative description of the distribution of the allowed costs, effective cost sharing and script counts by formulary tier to each of the categories on Worksheet 6.
   - 6.4. A quantitative description of the development of the total scripts, allowed dollars, and cost sharing for insulins and vaccines for the base period and projection period.
   - 6.5. A quantitative description of the development of the Manufacturer Discount PMPM for both LI and NLI members for the projection period.
   - 6.6. A quantitative description of the development of the rebates attributable to federal reinsurance on Worksheets 3, 4, and 5 including the distribution of applicable and non-applicable reinsurance allocations.
   - 6.7. A quantitative description of the development of the selected drug subsidy on Worksheet 6.

8.6. For a Part D plan without a corresponding Medicare Advantage plan, justification of benefit value in relation to the gain/loss margin, if the gain/loss margin as a percentage of revenue at the bid level is greater than 11.5 percent, or if the gain/loss margin as a percentage of revenue at the bid level is less than –10 percent and the bid has existed since CY2022. The required elements include—

- 8.6.1. A comparison of premiums for CY2026 and CY2025, if applicable. Include the Part D basic premium and Part D supplemental premium.

12. Detailed support for the data and methodology used in the development of appropriate manual rates for the expected population (Worksheet 2). The required elements include—
   - 12.1. A description of the source data, including, but not limited to, the data's relevance to the Part D bid, incurred dates, and the exposure (expressed in member months) that was used to develop the manual rate.
   - 12.2. An analysis justifying the reasonableness of the Part D manual rate, if the manual rate is based on experience of less than 60,000 member months of exposure.
   - 12.3. Any applicable adjustments to the source data, such as—
     - 12.3.1. Techniques and factors used to reflect differences between the underlying population and that expected of the Part D plan;
     - 12.3.2. Techniques and factors used to adjust for differences in plan design between the source data and the Part D plan; and
     - 12.3.3. Approach and factors applied to account for incomplete claim run-out, formulary differences and/or expenditures that are not reflected in the source data.
   - 12.4. Data and methodology used to project the data from the incurred period to CY2026.
   - 12.5. The distribution of member months, allowable costs, and scripts by benefit phase.
   - 12.6. All other applicable factors and/or adjustments.