DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

Date: August 6, 2012

To: All Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors

From: Jonathan D. Blum
Acting Principal Deputy Administrator &
Director, Center for Medicare

Subject: **Annual Release of Part D National Average Bid Amount and other Part C & D Bid Information**

CMS is announcing today that the Part D national average monthly bid amount for 2013 is $79.64, the 2013 Part D base beneficiary premium is $31.17, and the *de minimis* amount is $2. Please see the attached notice for more detailed information concerning the 2013 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, the Medicare Advantage regional PPO benchmarks, and information on the income related monthly adjustment amounts for enrollees in Part D prescription drug plans who have incomes above certain threshold amounts.

Detailed information regarding the *de minimis* amount is attached in a separate memo. The memo contains instructions and a timeline for volunteering to waive the *de minimis* amount and completing rebate reallocation. Plans will have until 11:59 PM Eastern Daylight Time (EDT) on Thursday, August 9th to complete rebate reallocation. Starting Friday, August 10, 2012 until 11:59 PM EDT Monday, August 13, 2012 plans can inform CMS of their intent to participate in the voluntary *de minimis* program.

If you have questions, please contact Ilina Chaudhuri at Ilina.Chaudhuri@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21207-0512

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

DATE: August 6, 2012

SUBJECT: **Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information**

Today we are releasing the 2013 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, information on the income-related monthly adjustment amounts for enrollees in Part D prescription drug plans who have incomes above certain threshold amounts, the Part D regional low-income premium subsidy amounts, and the Medicare Advantage regional PPO benchmarks.

Below we describe the determination of these amounts. The regional low-income premium subsidy amounts and the regional MA benchmarks can be downloaded from the CMS web site at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RegionalRatesBenchmarks2013.pdf

Part D National Average Monthly Bid Amount

In accordance with section 1860D-13(a)(4) of the Social Security Act ("the Act"), codified in 42 CFR §423.279, CMS has calculated the national average monthly bid amount for 2013. For each coverage year, CMS computes the national average monthly bid amount from the applicable Part D plan bid submissions in order to calculate the base beneficiary premium, as provided in 42 CFR §423.286(c).

The national average monthly bid amount is a weighted average of the standardized bid amounts for each prescription drug plan and for each MA-PD plan described in section 1851(a)(2)(A)(i) of the Act. The weights are based on the number of enrollees in that plan. The weight for each plan bid is equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the reference month (as defined in 42 CFR §422.258(c)(1)) and the denominator equal to the total number of Part D eligible individuals enrolled in the reference month in all applicable Part D plans. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, any "fallback" prescription drug plans, and plans established through reasonable cost reimbursement contracts under section 1876(h) of the Act. The reference month for the 2013 calculation was June 2012.

The national average monthly bid amount for 2013 is $79.64.

Part D Base Beneficiary Premium

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

In accordance with section 1860D-13(a) of the Act, codified in 42 CFR §423.286, Part D beneficiary premiums are calculated as the base beneficiary premium adjusted by the following factors: (i) the difference between the plan's standardized bid amount and the national average monthly bid amount; (ii) an increase for any supplemental premium; (iii) an increase for any late enrollment penalty; (iv) a decrease for Medicare Advantage Prescription Drug Plans (MA-PDs) that apply MA A/B rebates to buy down the Part D premium; and (v) elimination or decrease with the application of the low-income premium subsidy.

The Part D base beneficiary premium for 2013 is $31.17.[1]

Income Related Monthly Adjustment Amounts

Before consideration of premium adjustments based on income, Part D enrollee premiums vary from plan to plan and are calculated by comparing each plan's approved Part D bid to the national average monthly bid amount. A plan's basic Part D premium equals the base beneficiary premium plus the difference between the plan's bid and the national average monthly bid amount and may be reduced by MA rebates. (For Part D plans with enhanced alternative coverage, the plan-specific total premium includes premium amounts for supplemental benefits in addition to the basic premium.)

These adjustments were first effective January 1, 2011, as required by section 1860D-13(a)(7) of the Social Security Act.[2]

Under section 1860D-13(a)(7), if a beneficiary's "modified adjusted gross income" is greater than the specified threshold amounts ($85,000 in 2013 for a beneficiary filing an individual income tax return or married and filing a separate return, and $170,000 for a beneficiary filing a joint tax return), then the beneficiary is responsible for a larger portion of the total cost of Part D benefit coverage. In addition to the normal Part D premium paid to a plan, such beneficiaries must pay an income-related monthly adjustment amount. Unlike the normal Part D premium, beneficiaries will not pay the Part D income-related monthly adjustment amounts to Part D plans. Instead, the Part D income-related monthly adjustment amounts will be collected by the federal government.

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[1] As noted above, the actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium.

[2] This provision was added by section 3308 of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Shown in the following table are the 2013 Part D income-related monthly adjustment amounts to be paid by beneficiaries who file individual tax returns (including those who are single, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year), or who file joint tax returns:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Applicable Percentage	Part D income-related monthly adjustment amount
Less than or equal to $85,000	Less than or equal to $170,000	N/A	$0.00
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	35%	$11.60
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to 320,000	50%	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	65%	$48.30
Greater than $214,000	Greater than $428,000	80%	$66.60

As specified in section 1860D-13(a)(7), the Part D income-related monthly adjustment amounts are determined by multiplying the standard base beneficiary premium by the following ratios: (35% − 25.5%)/25.5%, (50% − 25.5%)/25.5%, (65% − 25.5%)/25.5%, or (80% − 25.5%)/25.5%.

For example:

$$\text{IRMAA}_{35\%} = \$31.17 \times \frac{35\%\text{-}25.5\%}{25.5\%} = \$11.61 \quad \text{(rounded to \$11.60)}$$

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file separate returns from their spouses and lived with their spouses at any time during the taxable year, are as follows:

Beneficiaries who are married but file separate tax returns from their spouses, with income:	Part D income-related monthly adjustment amount
Less than or equal to $85,000	$0.00
Greater than $85,000and less than or equal to $129,000	$48.30
Greater than $129,000	$66.60

Part D Regional Low-Income Premium Subsidy Amounts

In accordance with 42 CFR §423.780, full low-income subsidy (LIS) individuals are entitled to a premium subsidy equal to 100 percent of the premium subsidy amount. A Part D plan's premium subsidy amount is equal to an amount which is the lesser of the plan's premium for basic coverage or the regional low-income premium subsidy amount (LIPSA).

The regional LIPSAs are the greater of the low-income benchmark premium amount for a PDP region or the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the PDP region. In accordance with section 1860D-14 of the Social Security Act and the Final Rule "Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount," published in the Federal Register on April 3, 2008, the low-income benchmark premium amount for a PDP region is a weighted average of the monthly beneficiary premiums for basic prescription drug coverage in the region. The weight for each PDP and MA-PD plan is equal to a percentage—the numerator being equal to the number of Part D eligible LIS individuals enrolled in the plan in the reference month and the denominator equal to the total number of Part D eligible LIS individuals enrolled in all PDP and MA-PD plans in a Part D region in the reference month.

The Patient Protection Affordable Care Act amends the statute governing the calculation of the LIS benchmark premium amount (see section 3302, as amended by section 1102 of the Health Care and Education Reconciliation Act of 2010). As amended, Section 1860D-14(b)(3)(B)(iii) of the Act requires the calculation of the weighted average premium amounts described above using MA-PD basic Part D premiums before the application of Part C rebates each year.

The calculation does not include bids submitted by MA private fee-for-service plans, PACE programs under section 1894, "800 series" plans, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act ("Cost Plans"). The reference month for the 2013 calculation was June 2012.

The regional low-income premium subsidy amounts are provided in the file Regional Rates and Benchmarks 2013 which can be accessed on the CMS website through the following link: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RegionalRatesBenchmarks2013.pdf

MA Regional PPO Benchmarks

Per section 1858(f)(2), the standardized PPO benchmark for each MA region is a blend of two components: (i) a statutory component consisting of the weighted average of the county capitation rates across the region for each appropriate level of star rating; and (ii) a competitive, or plan-bid, component consisting of the weighted average of all of the standardized A/B bids for regional MA PPO plans in the region. (Such regional MA plan bids relate to the benefits covered under Parts A and B of Medicare.) The two components are then blended for each region, with the statutory component reflecting the national market share of traditional Medicare and the regional MA plan-bid component reflecting the market share of all MA organizations in the Medicare population nationally. In other words, the weights used to combine the statutory and competitive components of the benchmark are the same for all regions and equal the national

enrollment percentages for traditional Medicare and all MA plans. For 2013, the national weights applied to the statutory and plan-bid components are 73.2 percent and 26.8 percent, respectively.

The separate weighted-average statutory component and weighted-average competitive component in each region are determined based on the following weights:

- The weighting for the statutory component is based on all MA eligible individuals in the region—i.e., all Medicare beneficiaries who are either in the traditional, fee-for-service Medicare program or enrolled in MA plans and who are entitled to benefits under Part A and enrolled in Part B.
- The weighting for the plan-bid component is based on the enrollment in regional MA plans in the region for the reference month of June 2012. (That is, the weight for each plan's bid is based on the plan's market share in the region.)

The statutory and plan-bid components of the MA regional standardized benchmarks for 17 of the 26 MA regions[3] are in the file Regional Rates and Benchmarks 2013 which can be accessed on the CMS website through the following link: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RegionalRatesBenchmarks2013.pdf

/s/
Paul Spitalnic, A.S.A., M.A.A.A.
Director Parts C & D Actuarial Group
Office of the Actuary
Centers for Medicare & Medicaid Services

[3] In the remaining 9 MA regions, there are no regional MA plans.

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CENTER FOR MEDICARE

Date: August 6, 2012

To: All Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors

From: Cheri Rice, Director, Medicare Plan Payment Group

Subject: **Release of the *De Minimis* Amount and Operational Guidance**

In this memo CMS is releasing information regarding the *de minimis* amount as well as instructions and a timeline for volunteering to waive the *de minimis* amount and completing rebate reallocation. Plans will have until 11:59 PM Eastern Daylight Time (EDT) on Thursday, August 9, 2012 to complete rebate reallocation. Starting Friday, August 10, 2012 until 11:59 PM EDT Monday, August 13, 2012, plans can inform CMS of their intent to participate in the *de minimis* program.

De Minimis Amount

Under the Affordable Care Act (ACA) §3303(a), a prescription drug plan (PDP) or Medicare Advantage Plan with Prescription Drug coverage (MA-PD) may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is a *de minimis* amount above the low-income subsidy (LIS) benchmark for a subsidy eligible individual. The law prohibits CMS from reassigning LIS members from plans who volunteered to waive the *de minimis* amount.

The *de minimis* amount for 2013 will be $2.

Operational Considerations

Rebate Reallocation - Action by 11:59PM EDT on Thursday, August 9, 2012

Plan-specific information, such as plan standardized bid amounts, plan-specific premiums, and MA rebate dollars used, can be found at the following path in HPMS:

HPMS Home > Plan Bids > Bid Submission > Contract Year 2013 > Review Plan Data.

After reviewing the plan-specific information in HPMS, some bids may need to be resubmitted to adjust the MA rebate dollars in the Bid Pricing Tool (BPT). Local MA-only plans (which do not offer Part D), PDPs (which do not have MA rebates), and local employer plans (non-regional "800-series" plans) cannot resubmit their bids during the rebate reallocation period. In the instances when MA-PDs allocate all of their MA rebates to buy down the Part D basic premium, the MA-PD may volunteer to use the *de minimis* premium policy.

Guidance on rebate reallocation and premium rounding can be found in Appendix E of the Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2013. Changes to the Bid Pricing Tool must be in accordance with the guidance contained in Appendix E.

You will have until 11:59PM EDT on Thursday, August 9, 2012 to complete any resubmissions.

If resubmitting, the Part D bid pricing tools must reflect the final benchmarks released earlier in this announcement. No pricing changes will be accepted to the Part D bid forms. Since the Part D bid is not changing, there is no need to update the Date Prepared field in the PD BPT.

As a reminder, CMS expects MAOs to submit CY 2013 plan bids that satisfy our requirements, including but not limited to service category cost sharing, per member per month actuarial equivalence, Total Beneficiary Cost (TBC), and meaningful difference. CMS will not approve plan bids that do not satisfy our requirements.

A "final" actuarial certification must be submitted by all plans later this month. A separate announcement will be released regarding the submission of final actuarial certifications.

If you have questions about this information, please contact Jennifer Lazio at Jennifer.Lazio@cms.hhs.gov.

If you have technical questions about your resubmissions, please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov.

Volunteering to Waive the De Minimis Amount - Action by 11:59PM EDT on Monday, August 13, 2012

Eligible plans must actively inform CMS of their intent to participate in the *de minimis* program. Plans can inform CMS of their intent to participate starting Friday, August 10th until 11:59 PM EDT Monday, August 13th.

The mechanism to volunteer for *de minimis* can be found at the following path in HPMS:

HPMS Home>Plan Bids>Bid Submission>Contract Year 2013>Review Plan Data>Voluntary De Minimis

The 'Voluntary de minimis' link will be available at the left navigation bar. The default value will be unchecked (i.e., "No"), so eligible plans must select the checkbox to indicate that they want to volunteer to participate.

For questions, please contact Ilina Chaudhuri at Ilina.Chaudhuri@cms.hhs.gov.