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Center for Beneficiary Choices

Date: April 2, 2007

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

From: Abby L. Block
Director
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Subject: Notification of Changes in Medicare Part D Payment for Calendar Year 2008 (Part D Payment Notification)

This memo describes changes in the payment methodologies applied under Part D of the Act for Calendar Year (CY) 2008. The key changes in Part D payment methodologies for 2008 include: updated benefit parameters for the defined standard benefit and the Retiree Drug Subsidy (RDS); calculations of the national average monthly bid amount and the regional low-income benchmark premium amounts; normalization of the Part D risk adjustment model; and statutory changes in the risk corridors. This information applies to all Prescription Drug Plan (PDP) Sponsors, Medicare Advantage Organizations and others offering prescription drugs under Part D. Any changes to employer/union-only group waiver plan payment for 2008 will be issued in separate guidance. This memo is a key element of the information that CMS is providing to help organizations bid for the upcoming contract year.

Further Information

If you have specific questions about any of these changes, please contact Meghan Elrington at 410-786-8675 or Deondra Moseley at 410-786-4577.

2008 Part D Payment Notification
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I. Benefit Design

Section A. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2008

In accordance with section 1860D-2(b) of the Social Security Act (the Act), CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. These parameters include the annual deductible, initial coverage limit, annual out-of-pocket threshold, and minimum copayments for costs above the annual out-of-pocket threshold. As required by statute, the parameters for the defined standard benefit are indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. Accordingly, the actuarial value of the drug benefit increases along with any increase in Part D drug expenses, and the defined standard Part D benefit continues to cover a constant share of Part D drug expenses from year to year. All of the Part D benefit parameters are updated using one of two indexing methods specified by statute: (i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary or the "annual percentage increase", and (ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

The first indexing method, the "annual percentage increase", is used to update the following Part D benefit parameters:

(i) the deductible, initial coverage limit, and out-of-pocket threshold for the defined standard benefit,
(ii) minimum copayments for costs above the annual out-of-pocket threshold,
(iii) maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees,
(iv) the deductible for partial low-income subsidy (LIS) eligible enrollees, and
(v) maximum copayments above the out-of-pocket threshold for partial LIS eligible enrollees.

The benefit parameters listed above will be increased by 4.64% for 2008 as summarized by Table 1 below. This increase reflects the 2007 annual percentage trend of 6.19% as well as a multiplicative update of -1.47% for prior year revisions. Please see Appendix 1 for additional information on the calculation of the annual percentage increase.

Per 42 CFR 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated after 2006 in the same manner as the deductible and out-of-pocket threshold for the defined standard benefit. Thus, the "annual percentage increase" will be used to update these parameters as well. The cost threshold and cost limit for qualified retiree prescription drug plans will be increased by 4.64% from their 2007 values.

The second indexing method, the annual percentage increase in the CPI, is used to update the maximum copayments below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes that do not exceed 100% of the Federal poverty line. These maximum copayments will be increased by 2.42% for 2008 as summarized in Table 1 below. This increase reflects the 2007 annual percentage trend in CPI of 2.17%, as well as a multiplicative update of 0.25% for prior year revisions. Please see Appendix 1 for additional information on the calculation of the annual percentage increase in the CPI.

Table 1. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Annual Percentage Increases			
	Annual percentage trend for 2007	Prior year revisions	Annual percentage increase for 2007
Applied to all parameters but (1)	6.19%	-1.47%	4.64%
CPI (all items, U.S. city average): Applied to (1)	2.17%	0.25%	2.42%

Part D Benefit Parameters	2007	2008
Standard Benefit Design Parameters		
Deductible	$265	$275
Initial Coverage Limit	$2,400	$2,510
Out-of-Pocket Threshold	$3,850	$4,050
Total Covered Part D Drug Spend at OOP Threshold (2)	$5,451.25	$5,726.25
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.15	$2.25
Other	$5.35	$5.60
Part D Full Benefit Dual Eligible Parameters		
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	$1.00	$1.05
Other (3)	$3.10	$3.10
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.15	$2.25
Other	$5.35	$5.60
Above Out-of Pocket Threshold	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters		
Resources ≤ $6,120 (individuals) or ≤ $9,190 (couples) (4)		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.15	$2.25
Other	$5.35	$5.60
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Resources bet $6,120-$10,210 (ind) or $9,190-$20,410 (couples) (4)		
Deductible (3)	$53.00	$56.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.15	$2.25
Other	$5.35	$5.60
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$53.00	$56.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.15	$2.25
Other	$5.35	$5.60
Retiree Drug Subsidy Amounts		
Cost Threshold	$265	$275
Cost Limit	$5,350	$5,600

(1) CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% FPL.
(2) Amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.
(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2007 values of $53.43, $1.02 and $3.05, respectively.
(4) The actual amount of resources allowable will be updated for contract year 2008.

Section B. Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)

On July 20, 2006, CMS issued the memo "Modified Q&A Addressing Drug Costs Reported on Prescription Drug Events (PDEs)", which addressed how Part D sponsors should report drug costs to CMS. In this memo, CMS stated that a Part D Sponsor that uses a PBM may use either the lock-in amount or the pass-through amount as the basis for calculating beneficiary cost-sharing and gross covered drug costs throughout the benefit, as well as reporting drug costs on EOBs and PDE records.

In addition, we stated our intent to issue a Notice of Proposed Rulemaking proposing that the pass through model be the only acceptable methodology for 2008 and beyond. CMS is currently preparing this Notice of Proposed Rulemaking and we are committed to providing the public with sufficient time to comment on this proposed policy. However, we are aware that given the time required for public comment and to issue the final rule, Part D sponsors will not have sufficient time after the release of the final rule to prepare their 2008 bids in accordance with the policies established in this rule. Therefore, CMS intends to propose a single approach to determining beneficiary cost-sharing and gross covered drug costs, and for reporting drug costs to CMS, for 2009 instead of 2008 as indicated in the July 20th memo.

Therefore, for plan year 2008 as in 2006 and 2007, Part D sponsors that use a PBM may apply either the pass through or lock-in pricing approach when calculating cost-sharing and reporting drug costs. Part D sponsors must choose only one approach and cannot switch between them for purposes of calculating cost-sharing and reporting drug costs. Thus, the chosen pricing approach must be used consistently as a basis for: (i) calculating beneficiary cost-sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the Prescription Drug Event (PDE) records; and (v) developing bids submitted to CMS.

To ensure transparency in bid development, all plans will be required to submit an actuarial attestation, through HPMS and hardcopy, which identifies the pricing approach (lock-in or pass through) that was used in the development of each 2008 bid. Additional information regarding this attestation will be issued in future guidance.

II. Bidding

Section A. Calculation of the National Average Monthly Bid Amount

Beginning in 2007, section 1860D-13(a)(4)(B) of the Act directs CMS to calculate the national average monthly bid amount each year as a weighted average of the standardized bid amounts for each prescription drug plan (PDP) and Medicare Advantage Prescription Drug Plan (MA-PD) described in section 1851(a)(2)(A)(i) of the Act. It is weighted based on each plan's prior enrollment as a percentage of all Part D eligible individuals enrolled in these plans. Bids submitted by MSA plans, PFFS plans, SNP plans, PACE plans, Cost plans, and Fallback plans are not included in this calculation.

When calculating the national average monthly bid amount for contract year 2006, CMS assigned equal weighting to PDP sponsors, under section 1860D-13(a)(4)(B)(ii), because CMS

did not have prior enrollment for these Part D plans. MA-PD plans were assigned a weight based on their prior MA enrollments and new MA-PD plans were assigned zero weight.

In 2007, CMS began a transition from the 2006 method of calculating the national average monthly bid amount to the weighted average method based on actual plan enrollments under the "Medicare Demonstration to Limit Annual Changes in Part D Premiums Due to Beneficiary Choice of Low-Cost Plans". Under the demonstration, the national average monthly bid amount for 2007 is a composite of (i) a weighted average calculated using the 2006 weighting methodology and (ii) a weighted average calculated based on actual plan enrollments. In 2007, 80% of the national average monthly bid amount was based on the 2006 averaging methodology and 20% was based on the enrollment-weighted average. When the demonstration program cited above ends, the national average monthly bid amount will be a weighted average based on prior enrollment.

To continue the transition from the 2006 method of calculating the national average monthly bid amount to the enrollment-weighted average method, CMS is amending this demonstration to extend it for 2008. In 2008, 40% of the national average monthly bid amount will be based on the 2006 averaging methodology and 60% will be based on the enrollment-weighted average. The 2008 national average monthly bid amount and the reference month for the plan enrollment used to determine the enrollment-weighted average will be provided in future guidance after the June bid submission deadline.

Section B. Calculation of the Low-Income Benchmark Premium Amount

Section 1860D-14(b)(2) of the Act directs CMS to calculate annually the low-income benchmark premium amount for each PDP region. The low-income benchmark premium amount for each PDP region is determined by calculating a weighted average of the monthly beneficiary premiums for PDPs offering basic prescription drug coverage in the PDP region, the portion of the monthly beneficiary premium attributable to basic prescription drug coverage for PDPs offering enhanced alternative coverage in the PDP region, and the MA monthly prescription drug beneficiary premium for MA-PD plans in the PDP region, with the weighting based on plan enrollment. PACE, private fee-for-service plans, MSA plans, and section 1876 cost plans are not included in this calculation.

In determining the 2006 low-income benchmark premium amounts, PDPs were weighted equally as CMS did not have prior enrollment data for these Part D plans, and MA-PD plans were assigned a weight based on prior enrollment as of March 31, 2005. New MA-PD plans were assigned a zero weight.

In 2007, under the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries," CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006, i.e., all PDP bids were weighted equally, and MA-PD bids received weights based on plan enrollments in the reference month (June 2006).

CMS is amending the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries" so that it is extended to 2008. Starting in 2008, CMS will conduct a

transition from the 2006 methodology for calculating the regional low-income benchmark premium amounts to the methodology set forth at 42 CFR 423.780(b)(2), which requires calculation of a weighted-average based on actual plan enrollments. During the transition, the regional low-income benchmark premium amounts will be a composite of two different calculations: (1) a weighted average calculated using the 2006 weighting methodology, and (2) a weighted average calculated based on actual plan enrollments for both PDPs and MA-PD plans. In 2008, 50% of the regional low-income benchmark amount will be based on the 2006 weighting methodology and 50% will be based on the enrollment-weighted average. When the demonstration program cited above ends, the regional low-income benchmark premium amounts will be a weighted average based on prior enrollment in accordance with the methodology set forth at 42 CFR 423.780(b)(2).

Under the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," in 2007 Part D plans are required to charge full subsidy eligible beneficiaries a monthly beneficiary premium equal to the applicable low-income benchmark premium amount, if the plan's monthly beneficiary premium attributable to basic prescription drug coverage exceeds the low-income benchmark premium amount by $2 or less (the "*de minimis* amount"). CMS is amending the demonstration and extending the *de minimis* policy to 2008. The *de minimis* amount for 2008 will be $1.

III. Risk Adjustment

Section A. Normalization of the Part D Risk Adjustment Model.

When we calibrate a risk adjustment model, we establish model coefficients that will result in the average beneficiary risk score being equal to 1.0 in the calibration year. Over time, risk scores rise due to population and coding changes. The result is that, over time, the average beneficiary risk in future years is greater than 1.0. This phenomenon has occurred with Part D and the average Part D beneficiary risk score now exceeds 1.0. Adjusting model coefficients so that the average beneficiary risk score will equal 1.0 in future years is called normalization.

In order for CMS to pay a plan for the appropriate risk of its enrollees, Part D sponsors bid their revenue needs based on their expected population and then adjust, or standardize, their bid using the expected average risk score of their projected enrollees; the standardized bid is the revenue needed by that plan to provide coverage to the average (1.0) beneficiary. When CMS calculates payment, the plan enrollees' actual risk scores are used to adjust the direct subsidy paid to each plan; in this way, plan payment is adjusted for the expected relative costliness of their enrollees.

In the absence of normalization, rising Part D risk scores will lead to reduced standardized bids and, as a result, in a lower national average monthly bid amount and a lower base beneficiary premium. The formula for the Part D direct subsidy is:

*Direct subsidy = standardized bid * beneficiary risk score – beneficiary premium*

Ultimately, non-normalized risk scores result in lower beneficiary premiums that are balanced out by increased direct subsidy payments. As seen in the formula for the direct subsidy payment (above), lower beneficiary premiums result in higher direct subsidy payments.

To calculate a normalization factor that would set the average risk score for all potential Part D plan enrollees to 1.0 for 2008 plan payments, we calculated an annual trend factor in the risk scores and applied an adjustment, using this trend factor, to project risk scores for 2008. This Part D normalization factor is 1.065 for 2008. This downward adjustment, which helps ensure that the average risk score across all Part D plans equals 1.0, will not affect total plan revenue. It will, however, affect the calculation of the beneficiary premium and the direct subsidy and thereby the share of the bid paid for by the beneficiary (through the plan beneficiary premium) and by the Federal government (through the direct subsidy). Further guidance on how CMS will apply this Part D normalization factor will be provided in the 2008 Part D bid instructions.

Section B. Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment

Each year, CMS publishes on its website a list of the valid ICD-9-CM codes for the following fiscal year, based on the recommendations of the ICD-9-CM Coordination and Maintenance Committee. All final decisions on valid codes are made by the Director of the National Center for Health Statistics (NCHS) and the Administrator of CMS. NCHS, a component of the Centers for Disease Control, has the lead on ICD-9-CM diagnosis issues. The published code sets can be found at http://www.cdc.gov/nchs/icd9.htm. More information on the process for updating valid ICD-9 codes can be found at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage.

In 2009, we are moving to a standard set of codes against which to validate the diagnoses received from plans into our Risk Adjustment System (RAS). The goal of this transition to a standard set of codes for a payment year is to synchronize the list of codes RAS accepts and stores (acceptable codes) with the list of valid codes. Currently, there are more acceptable codes than valid codes because RAS is "flexible" (e.g., still accepts and stores an old ICD-9 code that has been superseded by a later NCHS code, and does not send an error message to the plan). Having a standard set of codes for each year will make it easier for CMS and plans to manage risk adjustment processing, editing, and error reporting.

As described in Table II below, starting with 2009 payment, the list of acceptable ICD-9-CM codes for the CMS-HCC, ESRD, and RxHCC risk adjustment models for risk adjustment for any given payment year will comprise the list of published NCHS/CMS codes (valid codes) for the three fiscal years prior to and including the payment year. The list of currently acceptable codes can be found on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

CMS will issue guidance as soon as possible with further detail on the transition to a standard set of codes for payment year 2009.

Table II. Phase-in Schedule for New Lists of Diagnosis Codes for Risk Adjustment

Year of Payment	Date of Service	Source of codes
2007	1/06 – 12/06	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2008	1/07 – 12/07	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2006, 2007, 2008
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2007, 2008, 2009
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2008, 2009, 2010

IV. Payment Reconciliation

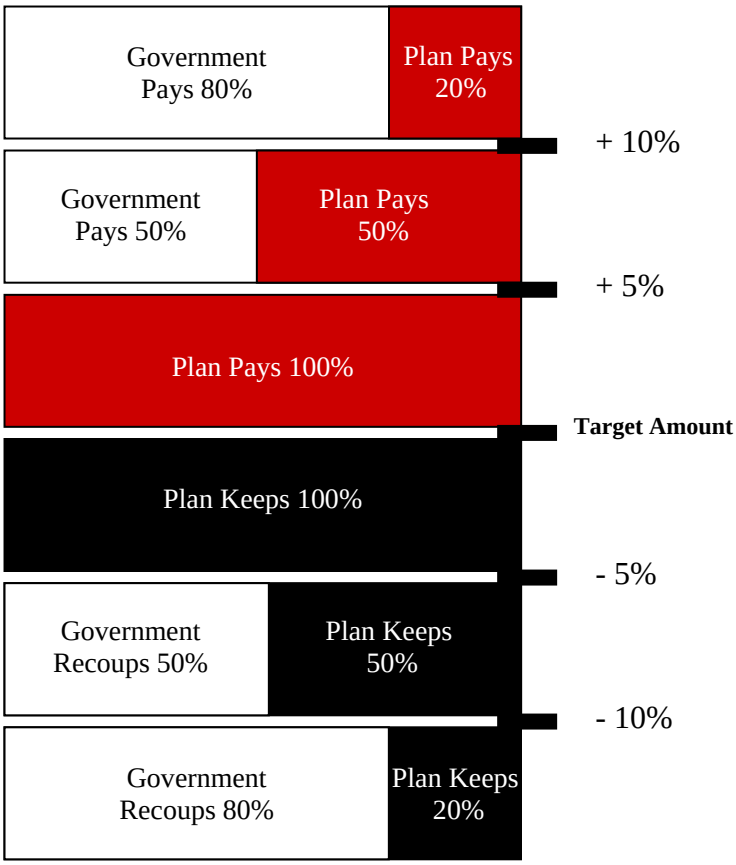
Section A. Part D Risk Sharing for 2008 through 2011

Pursuant to section 1860D-15(e) of the Act and the regulations at 42 CFR 423.336, the following changes will be made to the risk sharing arrangements for contract years 2008 through 2011:

- The first threshold risk percentage changes from 2.5% to 5% of the target amount;
- The second threshold risk percentage changes from 5% to 10% of the target amount;
- The payment adjustments for the first corridor change from 75% to 50% and the second corridor remains at 80%; and
- The conditions for higher percentages (a.k.a. 60/60 rule) under Section 1860D-15(e)(2)(B)(iii) of the Act and the regulations at 42 CFR 423.336(b)(2)(iii) will no longer be applicable.

Figure 1 below describes the risk corridors for 2008 through 2011.

Figure 1. Part D Risk Corridors for 2008-2011



V. Appendix 1

Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2008

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These parameters include the standard deductible, initial coverage limit, and catastrophic coverage threshold, and minimum copayments for costs above the annual out-of-pocket threshold. In addition, CMS is statutorily required to update the parameters for the low income subsidy benefit and the cost threshold and cost limit for qualified retiree prescription drug plans eligible for the Retiree Drug Subsidy. Included in this notice are (i) the methodologies for updating these parameters, (ii) the updated parameter amounts for the Part D defined standard benefit and low-income subsidy benefit for 2008, and (iii) the updated cost threshold and cost limit for qualified retiree prescription drug plans.

As required by statute, the parameters for the defined standard benefit formula are indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. Accordingly, the actuarial value of the drug benefit increases along with any increase in drug expenses, and the defined standard Part D benefit continues to cover a constant share of drug expenses from year to year.

All of the Part D benefit parameters are updated using one of two indexing methods specified by statute: (i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary, and (ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

I. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

Section 1860D-2(b)(6) of the Social Security Act defines the "annual percentage increase" as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following parameters are updated using the "annual percentage increase":

Deductible: From $265 in 2007 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $2,400 in 2007 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $3,850 in 2007 and rounded to the nearest multiple of $50.

Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.15 per generic or preferred drug that is a multi-source drug, and $5.35 for all other drugs in 2007, and rounded to the nearest multiple of $0.05.

Maximum Copayments below the Out-of-Pocket Threshold for certain Low Income Full Subsidy Eligible Enrollees: From $2.15 per generic or preferred drug that is a multi-source drug, and $5.35 for all other drugs in 2007, and rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $53[1] in 2007 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.15 per generic or preferred drug that is a multi-source drug, and $5.35 for all other drugs in 2007, and rounded to the nearest multiple of $0.05.

II. Annual Percentage Increase in Consumer Price Index, All Urban Consumers (all items, U.S. city average)

Section 1860D-14(a)(4) of the Social Security Act specifies that the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year is used to update the maximum copayments below the out-of-pocket threshold for full benefit dual eligible enrollees with incomes that do not exceed 100% of the Federal poverty line. These copayments are increased from $1 per generic or preferred drug that is a multi-source drug, and $3.10 for all other drugs in 2007[2], and rounded to the nearest multiple of $0.05 and $0.10, respectively.

III. Calculation Methodology

Annual Percentage Increase

The first time CMS will have Part D program data that can be used in the calculation of the annual percentage increase, as defined in section 1860D-2(b)(6) of the Social Security Act, will be in 2008 for the 2009 contract year benefit parameters. Therefore, until sufficient Part D program data becomes available, the National Health Expenditure (NHE) prescription drug per capita estimates will be used. The annual percentage trend for the 2008 benefit formula is based on the estimated NHE prescription drug per capita costs as follows:

[1] Consistent with the statutory requirements of 1860D-14(a)(4)(B) of the Social Security Act, the update for the deductible for low income (partial) subsidy eligible enrollees is applied to the unrounded 2007 value of $53.43.

[2] Consistent with the statutory requirements of 1860D-14(a)(4)(A) of the Social Security Act, the copayments are increased from the unrounded 2007 values of $1.02 per generic or preferred drug that is a multi-source drug, and $3.05 for all other drugs.

$$\frac{\textit{August } 2006 - \textit{July } 2007}{\textit{August } 2005 - \textit{July } 2006} = \frac{\frac{5}{12}(CY\ 2006) + \frac{7}{12}(CY\ 2007)}{\frac{5}{12}(CY\ 2005) + \frac{7}{12}(CY\ 2006)} = \frac{\frac{5}{12}(\$714) + \frac{7}{12}(\$761)}{\frac{5}{12}(\$676) + \frac{7}{12}(\$714)} = 1.0619$$

(Source: Prescription Drug Spending, National Health Accounts, 1960-2015; National Health Statistics Group; February, 2007; Table #11 at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf)

The 2008 benefit parameters reflect the 2007 annual percentage trend as well as a revision to the prior estimate for the 2006 annual percentage increase. The 2007 parameter update reflected an annual percentage increase of 6.86%. Based on the updated NHE prescription drug per capita costs, the 2007 increase is now estimated to be 5.29%. Accordingly, the 2008 benefit parameters reflect a multiplicative update of -1.47% (1.0529/1.0686 – 1) for prior year revisions. In summary, the 2007 parameters outlined in section I are updated by 4.64% for 2008 as summarized by Table III-1.

Table III-1. Annual Percentage Increase

Annual percentage trend for July 2007	6.19%
Prior year revisions	-1.47%
Annual percentage increase for 2007	4.64%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

Annual Percentage Increase in Consumer Price Index, All Urban Consumers (all items, U.S. city average)

The annual percentage increase in the CPI as of September of the previous year referenced in section 1860D-14(a)(4)(A)(ii) is interpreted to mean that, for contract year 2008, the September 2007 CPI should be used in the calculation of the index. To ensure that plan sponsors and CMS have sufficient time to incorporate the cost-sharing requirements into benefit, marketing material and systems development, the methodology to calculate this update includes an estimate of the September 2007 CPI based on the projected amount included in the President's FY2008 Budget. The September 2006 value is from the Bureau of Labor Statistics. The annual percentage trend in CPI for contract year 2008 is calculated as follows:

$$\frac{\text{Projected September 2007 CPI}}{\text{Actual September 2006 CPI}}\ \textit{or}\ \frac{207.3}{202.9} = 1.0217$$

(Source: President's FY2008 Budget and Bureau of Labor Statistics, Department of Labor)

The 2008 benefit parameters reflect the 2007 annual percentage trend in the CPI, as well as a revision to the prior estimate for the 2006 annual percentage increase. The 2007 parameter update reflected an annual percentage increase in CPI of 1.81%. Based on the actual reported CPI for September 2006, the September 2006 CPI increase is now estimated to be 2.06%. Thus, the 2008 update reflects a multiplicative 0.25% (1.0206/1.0181 – 1) correction for prior year revisions. In summary, the cost sharing items outlined in section II are updated by 2.42% for 2008 as summarized by Table III-2.

Table III-2. Cumulative Annual Percentage Increase in CPI

Annual percentage trend for September 2007	2.17%
Prior year revisions	0.25%
Annual percentage increase for 2007	2.42%

Note: Percentages are multiplicative, not additive. Values are carried to additional decimal places and may not agree to the rounded values presented above.

IV. Part D Payment Demonstration Adjustment

The fixed capitated option of the Part D Payment Demonstration includes a catastrophic benefit that begins at the total drug expense corresponding to the out-of-pocket threshold in the Defined Standard Benefit. For 2008, this amount is increased from $5,451.25 in 2007 to $5,726.50 Specifically, this is the minimum amount of total covered Part D drug expenditures that will have occurred when the beneficiary reaches the out-of-pocket threshold of $4,050 in 2008 in the defined standard benefit. This expense level is determined arithmetically as a function of the 2008 out-of-pocket threshold (as opposed to being indexed directly).

V. Retiree Drug Subsidy Amounts

As outlined in §423.886(b)(3) of the regulations implementing the Part D benefit, the cost threshold and cost limit for qualified retiree prescription drug plans that end in years after 2006 are adjusted in the same manner as the annual Part D deductible and out-of-pocket threshold are adjusted under §423.104(d)(1)(ii) and (d)(5)(iii)(B), respectively. Specifically, they are adjusted by the "annual percentage increase" as defined previously in this document and the cost threshold is rounded the nearest multiple of $5 and the cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $250 and $5,000, respectively, for plans that end in 2006, and, as $265 and $5,350, respectively, for plans that end in 2007. For 2008, the cost threshold is increased to $275, and the cost limit is increased to $5,600.