based HMOs or CMPs offering section 1876 cost plans including qualified prescription drug coverage, may include a uniform modification of the amount of risk assumed (based on a process to be specified) as described in one or more of the following paragraphs. Any such modification applies to all plans offered by the PDP sponsor in a PDP region.

1. Increase in Federal percentage assumed in initial risk corridor. An equal percentage point increase in the per cents applied for costs between the first and second threshold limits under 423.336(b)(2)(i) and (b)(2)(ii)(A) and 423.336 (b)(3)(i) and (b)(3)(ii)(A). This provision does not affect the application of a higher percentage for plans in 2006 or 2007 under §423.336(b)(2)(iii).

2. Increase in Federal percentage assumed in second risk corridor. An equal percentage point increase in the per cents applied for costs above the second threshold upper limit or below the second threshold upper limit under paragraphs §423.336(b)(2)(ii)(B) and (b)(3)(ii)(B).

3. Decrease in size of risk corridors. A decrease in the size of the risk corridors by means of reductions in the threshold risk percentages specified in §423.336(a)(2)(i)(A) and/or (a)(2)(ii)(B).

(f) Special rule for fallback prescription drug plans. Fallback prescription drug plan bids are not subject to the rules in this section. They must follow requirements specified in §423.863.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19818, Apr. 15, 2010]

§423.272 Review and negotiation of bid and approval of plans submitted by potential Part D sponsors.

(a) Review and negotiation regarding information, terms and conditions. CMS reviews the information filed under §423.265(c) in order to conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan. In addition to its general negotiating authority under section 1860D–11(d)(2)(A) of the Act, CMS has authority similar to that of the Director of the Office of Personnel Management for health benefit plans under Chapter 89 of title 5, U.S.C.

(b) Approval of proposed plans. CMS approves the Part D plan only if the plan and the Part D sponsor offering the plan comply with all applicable CMS Part D requirements, including those related to the provision of qualified prescription drug coverage and actuarial determinations.

1. Application of revenue requirements standard. CMS approves a bid submitted under §423.265 only if it determines that the portions of the bid attributable to basic and supplemental prescription drug coverage are supported by the actuarial bases provided and reasonably and equitably reflect the revenue requirements (as used for purposes of section 1302(b)(C) of the Public Health Service Act) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under §423.329(c).

2. Plan design. (i) CMS does not approve a bid if it finds that the design of the plan and its benefits (including any formulary and tiered formulary structure) or its utilization management program are likely to substantially discourage enrollment by certain Part D eligible individuals under the plan.

(ii) If the design of the categories and classes within a formulary is consistent with the model guidelines (if any) established by the United States Pharmacopeia, the formulary categories and classes alone will not be found to discourage enrollment.

(iii) A plan that adopts the categories and classes discussed in paragraph (b)(2)(ii) of this section may nevertheless be found to discourage enrollment because it excludes specific drugs from the formulary.

3. Substantial differences between bids—(i) General. CMS approves a bid only if it finds that the benefit package or plan costs represented by that bid are substantially different as provided under §423.265(b)(2) of this subpart from the benefit package or plan costs represented by another bid submitted by the same Part D sponsor.

(ii) Transition period for PDP sponsors with new acquisitions. After a 2-year transition period, as determined by CMS, CMS approves a bid offered by a
§ 423.279 National average monthly bid amount.

(a) Bids included. For each year (beginning with 2006) CMS computes a national average monthly bid amount from approved bids submitted under §423.265 in order to calculate the base beneficiary premium, as provided in §423.286(c). The national average monthly bid amount is equal to a weighted average of the standardized bid amounts for each prescription drug plan (not including fallbacks) and for each MA-PD plan described in section 1851(a)(2)(A)(i) of the Act. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act.

(b) Calculation of weighted average. (1) The national average monthly bid amount is a weighted average, with the weight for each plan equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the reference month (as defined in §422.258(c)(1) of this chapter) and the denominator equal to the total number...