Centers for Medicare & Medicaid Services, HHS

§ 423.308

D—IRMAA must be paid through withholding from the enrollee’s Social Security benefit payments, or benefit payments by the Railroad Retirement Board (RRB) or the Office of Personnel Management (OPM) in the manner that the Part B premium is withheld.

(2) Collection through direct billing. In cases where an enrollee’s benefit payment check is not sufficient to have the Part D—IRMAA withheld, or if an enrollee is not receiving such benefits, the beneficiary will have the option of paying the amount through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or according to other means that CMS may specify.

(3) Failure to pay the income-related monthly adjustment amount: General rule. CMS will terminate Part D coverage for any individual who fails to pay the Part D—IRMAA as determined by the Social Security Administration. CMS will terminate an enrollee’s Part D coverage as specified in §423.44(e).

(e) Special rule for fallback plans. This section does not apply to fallback prescription drug plans. The fallback plans follow the requirements set forth in §423.867(b).

(f) Prohibition on improper billing of premiums. Part D plan sponsors shall not bill an enrollee for a premium payment period if the enrollee has had the premium for that period withheld from his or her Social Security, Railroad Retirement Board or Office of Personnel Management check.


Subpart G—Payments to Part D Plan Sponsors For Qualified Prescription Drug Coverage

§ 423.301 Scope.

This subpart sets forth rules for the calculation and payment of CMS direct and reinsurance subsidies for Part D plans; the application of risk corridors and risk-sharing adjustments to payments; and retroactive adjustments and reconciliations to actual enroll-
profit or loss retained by an intermediary contracting organization (through discounts, rebates, or other direct or indirect price concessions) when negotiating prices with dispensing entities is considered an administrative cost.

*Allowable reinsurance costs* means the subset of gross covered prescription drug costs actually paid that are attributable to basic prescription drug coverage for covered Part D drugs only and that are actually paid by the Part D sponsor or by (or on behalf of) an enrollee under the Part D plan. The costs for any Part D plan offering enhanced alternative coverage must be adjusted not only to exclude any costs attributable to benefits beyond basic prescription drug coverage, but also to exclude any costs determined to be attributable to increased utilization over the standard prescription drug coverage as the result of the insurance effect of enhanced alternative coverage in accordance with CMS guidelines on actuarial valuation.

*Coverage year* means a calendar year in which covered Part D drugs are dispensed if the claim for those drugs (and payment on the claim) is made not later than 3 months after the end of the year.

*Gross covered prescription drug costs* mean those actually paid costs incurred under a Part D plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:

1. The share of actual costs (as defined by §423.100 of this part) actually paid by the Part D plan that is received as reimbursement by the pharmacy, or other dispensing entity, reimbursement paid to indemnify an enrollee when the reimbursement is associated with an enrollee obtaining covered Part D drugs under the Part D plan, or payments made by the Part D sponsor to other parties listed in §423.464(f)(1) of this part with which the Part D sponsor must coordinate benefits, including other Part D plans, or as the result of any reconciliation process developed by CMS under §423.464 of this part.

2. Nominal cost-sharing paid by or on behalf of an enrollee which is associated with drugs that would otherwise be covered Part D drugs, as defined in §423.100 of this part, but are instead paid for, with the exception of said nominal cost-sharing, by a patient assistance program providing assistance outside the Part D benefit, provided that documentation of such nominal cost-sharing has been submitted to the Part D plan consistent with the plan processes and instructions for the submission of such information.

3. All amounts paid under the Part D plan by or on behalf of an enrollee (such as the deductible, coinsurance, cost sharing, or amounts between the initial coverage limit and the out-of-pocket threshold) in order to obtain Part D drugs that are covered under
the Part D plan. If an enrollee who is paying 100 percent cost sharing (as a result of paying a deductible or because the enrollee is between the initial coverage limit and the out-of-pocket threshold) obtains a covered Part D drug at a lower cost than is available under the Part D plan, such cost-sharing will be considered an amount paid under the plan by or on behalf of an enrollee under the previous sentence of this definition, if the enrollee’s costs are incurred costs as defined under § 423.100 of this part and documentation of the incurred costs has been submitted to the Part D plan consistent with plan processes and instructions for the submission of such information. These costs are determined regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

Target amount means the total amount of payments (from both CMS and by or on behalf of enrollees) to a Part D plan for the coverage year for all standardized bid amounts as risk adjusted under § 423.329(b)(1) of this part, less the administrative expenses (including return on investment) assumed in the standardized bids.

§ 423.315 General payment provisions.

(a) Source of payments. CMS payments under this section are made from the Medicare Prescription Drug Account.

(b) Monthly payments. CMS provides a direct subsidy in the form of advance monthly payments equal to the Part D plan’s standardized bid, risk adjusted for health status as provided in § 423.329(b), minus the monthly beneficiary premium as determined in § 423.286.

(c) Reinsurance subsidies. CMS provides reinsurance subsidy payments described in § 423.329(c) on a monthly basis during a year based on either estimated or incurred allowable reinsurance costs as provided under § 423.329(c)(2)(i), and final reconciliation to actual allowable reinsurance costs as provided in § 423.343(c).

(d) Low-income subsidies. CMS makes payments for premium and cost sharing subsidies, including additional coverage above the initial coverage limit, on behalf of certain subsidy-eligible individuals as provided in §§ 423.780 and 423.782. CMS provides low-income cost-sharing subsidy payments described in § 423.782 through interim payments of amounts as provided under § 423.329(d)(2)(i) and reconciliation to actual allowable reinsurance costs as provided in § 423.343(d).

(e) Risk-sharing arrangements. CMS may issue lump-sum payments or adjust monthly payments in the following payment year based on the relationship of the Part D plan’s adjusted allowable risk corridor costs to predetermined risk corridor thresholds in the coverage year as provided in § 423.336.

(f) Retroactive adjustments and reconciliations. CMS reconciles payment year disbursements with updated enrollment and health status data, actual low-income cost-sharing costs and actual allowable reinsurance costs as provided in § 423.336.

(g) Special rules for private fee-for-service plans—(1) Application of reinsurance. For private fee-for-service plans (as defined by § 422.4(a)(3) of this chapter) offering qualified prescription drug coverage, CMS determines the amount of reinsurance payments as provided under § 423.329(c)(3).

(2) Exemption from risk corridor provisions. The provisions of § 423.336 regarding risk sharing do not apply.

§ 423.322 Requirement for disclosure of information.

(a) Payment conditional upon provision of information. Payments to a Part D sponsor are conditioned upon provision of information to CMS that is necessary to carry out this subpart, or as required by law.

(b) Restrictions on use of information. (1) Officers, employees, and contractors of the Department of Health and Human Services may use the information disclosed or obtained in accordance with the provisions of this subpart for the purposes of, and to the extent necessary—

(i) In carrying out this subpart, including, but not limited to, determination of payments, and payment-related oversight and program integrity activities.