

(2) *CAHPS adjustments.* (i) A contract, even if an affected contract, must administer the CAHPS survey unless exempt under paragraph (i)(2)(ii) of this section.

(ii) An affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance is exempt from administering the CAHPS survey if the contract completes both of the following:

(A) Demonstrates to CMS that the required sample for the survey cannot be contacted because a substantial number of the contract's enrollees are displaced due to the FEMA-designated disaster identified in paragraph (i)(1)(iii) of this section in the prior calendar year.

(B) Requests and receives a CMS approved exemption.

(iii) An affected contract with an exemption described in paragraph (i)(2)(ii) of this section receives the contract's CAHPS measure stars and corresponding measure scores from the prior year.

(iv) For an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance, the contract receives the higher of the previous year's Star Rating or the current year's Star Rating (and corresponding measure score) for each CAHPS measure.

(v) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(3) *New measure adjustments.* For affected contracts with at least 25 per-

cent of enrollees in a FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance, CMS holds the affected contract harmless by using the higher of the contract's summary or overall rating or both with and without including all of the applicable new measures.

(4) *Other Star Ratings measure adjustments.* (i) For all other Part D measures except those measures identified in this paragraph (i)(4)(ii) of this section, affected contracts with at least 25 percent of enrollees in a FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance receive the higher of the previous or current year's measure Star Rating (and corresponding measure score).

(ii) CMS does not adjust the scores of the Star Ratings for the Part D Call Center—Foreign Language Interpreter and TTY Availability measure, unless the exemption listed in paragraph (i)(4)(iii) of this section applies.

(iii) CMS adjusts the measure listed in paragraph (i)(4)(ii) of this section using the adjustments listed in paragraph (i)(4)(i) of this section for contracts affected by extreme and uncontrollable circumstances where there are continuing communications issues related to loss of electricity and damage to infrastructure during the call center study.

(iv) When a contract is an affected contract with at least 25 percent of enrollees in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance with regard to separate extreme and uncontrollable circumstances that begin in successive years, it is a multiple year-affected contract. A multiple year-affected contract receives the higher of the current year's Star Rating or what the previous year's Star Rating would have been in the absence of any adjustments that took into account the effects of the previous year's disaster for each measure (using the corresponding measure score for the Star Ratings year selected).

(5) *Exclusion from improvement measures.* Any measure that reverts back to the data underlying the previous year's Star Rating due to the adjustments made in paragraph (i) of this section is

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excluded from both the count of measures and the applicable improvement measures for the current and next year's Star Ratings for the affected contract. Contracts affected by extreme and uncontrollable circumstances do not have the option of reverting to the prior year's improvement rating.

(6) *Missing data.* For an affected contract that has missing data in the current or previous year, the final measure rating comes from the current year unless an exemption described in paragraph (i)(2)(ii) of this section applies. Missing data includes data where there is a data integrity issue as defined at § 423.184(g)(1).

(7) *Cut points for non-CAHPS measures.*

(i) Through the 2025 Star Ratings, CMS excludes the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance from the clustering algorithms described in paragraph (a)(2) of this section.

(ii) The cut points calculated as described in paragraph (i)(7)(i) of this section are used to assess all affected contracts' measure Star Ratings.

(8) *Reward factor.* (i) Through the 2025 Star Ratings, CMS excludes the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance from the determination of the performance summary and variance thresholds for the reward factor described in paragraph (f)(1) of this section.

(ii) All affected contracts are eligible for the Reward Factor based on the calculations described in paragraph (i)(8)(i) of this section.

(9) *Special rules for the 2022 Star Ratings only.* For the 2022 Star Ratings only, CMS will not apply the provisions in paragraph (i)(7) or (8) of this section and CMS will not exclude the numeric values for affected contracts with 60 percent or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance from the clustering algorithms or from the determination of the performance

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summary and variance thresholds for the Reward Factor.

(j) *Special rules for 2021 Star Ratings only.* (1) For the 2021 Star Ratings:

(i) The measures calculated based on CAHPS data are calculated based on survey data collected from March through May 2019.

(ii) The measure-level change score calculation described at § 423.184(f)(4)(i) is not applied for CAHPS measures and the measure-level change score used for the 2020 Star Ratings is applied in its place for all CAHPS-based measures.

(iii) The provisions of § 423.184(g)(2) are not applied for failure to submit CAHPS-based measures.

(iv) [Reserved]

(2) [Reserved]

[83 FR 16743, Apr. 16, 2018, as amended at 84 FR 15842, Apr. 16, 2019; 85 FR 19291, Apr. 6, 2020; 85 FR 33911, June 2, 2020; 85 FR 54872, Sept. 2, 2020; 86 FR 6118, Jan. 19, 2021; 87 FR 27899, May 9, 2022; 88 FR 22338, Apr. 12, 2023; 89 FR 30835, Apr. 23, 2024]

### Subpart E [Reserved]

### Subpart F—Submission of Bids and Monthly Beneficiary Premiums; Plan Approval

#### § 423.251 Scope.

This section sets forth the requirements and limitations on submission, review, negotiation and approval of competitive bids for prescription drug plans and MA-PD plans; the calculation of the national average bid amount; and the determination of enrollee premiums.

#### § 423.258 Definitions.

For the purposes of this subpart, the following definitions apply:

*Full risk plan* means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

*Limited risk plan* means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in § 423.265(d) in its bid submitted for the plan. This term does not include a fallback prescription drug plan.

*Standardized bid amount* means, for a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid; for a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage; for a MA-PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

**§ 423.265 Submission of bids and related information.**

(a) *Eligibility for bidding.* An applicant may submit a bid to become a Part D plan sponsor.

(b) *Bid submission*—(1) *General.* Not later than the first Monday in June, each potential Part D sponsor must submit bids and supplemental information described in this section for each Part D plan it intends to offer in the subsequent calendar year.

(2) *Substantial differences between bids*—(i) *General rule.* Except as provided in paragraph (b)(2)(ii) of this section, potential Part D sponsors' bid submissions must reflect differences in benefit packages or plan costs that CMS determines to represent substantial differences relative to a sponsor's other bid submissions. In order to be considered "substantially different," each bid must be significantly different from the sponsor's other bids with respect to beneficiary out-of-pocket costs or formulary structures.

(ii) *Exception.* A potential Part D sponsor's enhanced bid submission does not have to reflect the substantial differences as required in paragraph (b)(2)(i) of this section relative to any of its other enhanced bid submissions.

(3) *Limit on number of plan offerings.* Potential Part D sponsors' bid submissions may include no more than three stand-alone prescription drug plan offerings in a service area and must include only one basic prescription drug plan offering.

(4) *Bid acceptance.* CMS may decline to accept any or every bid submitted by a Part D sponsor or potential Part D sponsor.

(5) *Limitations on changes.* After a Part D sponsor is permitted to begin marketing prospective plan year offer-

ings for the following contract year (consistent with § 423.2263(a)), the Part D sponsor must not change, and must provide the benefits described in its CMS-approved plan benefit package (PBP) (as defined at § 423.182) for the contract year without modification, except where a modification in benefits is required by law.

(c) *Basic rule for bid.* Each potential Part D sponsor must submit a bid and supplemental information in a format to be specified by CMS for each Part D plan it offers. Each bid must reflect a uniform benefit package, including premium (except as provided for the late enrollment penalty described in § 423.286(d)(3)) and all applicable cost sharing, for all individuals enrolled in the plan. Each bid must reflect the applicant's estimate of its average monthly revenue requirements to provide qualified prescription drug coverage (including any supplemental coverage) for a Part D eligible individual with a national average risk profile for the factors described in § 423.329(b)(1).

(1) *Included costs.* The bid includes costs (including administrative costs and return on investment/profit) for which the plan is responsible in providing basic and supplemental benefits.

(2) *Excluded costs.* The bid does not include costs associated with payments by the enrollee for deductible, co-payments, coinsurance, and liability above the plan allowance in the case of out-of-network claims, payments projected to be made by CMS for reinsurance, or any other costs for which the sponsor is not responsible.

(3) *Actuarial valuation.* The bid must be prepared in accordance with CMS actuarial guidelines based on generally accepted actuarial principles. A qualified actuary must certify the plan's actuarial valuation (which may be prepared by others under his or her direction or review), and must be a member of the American Academy of Actuaries to be deemed qualified. Applicants may use qualified outside actuaries to prepare their bids.

(d) *Specific requirements for bids.* The bid and supplemental information submission must include the following information:

(1) *Coverage.* A description of the coverage to be provided under the plan, including any supplemental coverage and the deductible and other cost sharing.

(2) *Actuarial value of bid components.* The applicant must provide the following information on bid components, as well as actuarial certification that the values are calculated according to CMS guidelines on actuarial valuation, including adjustment for the effect that providing alternative prescription drug coverage (rather than defined standard prescription drug coverage) has on drug utilization, if applicable.

(i) The actuarial value of the qualified prescription drug coverage to be offered under each plan for a Part D eligible individual with a national average risk profile for the factors described in § 423.329(b)(1) and the basis for the estimate.

(ii) The portion of the bid attributable to basic prescription drug coverage and the portion (if any) attributable to supplemental benefits.

(iii) The assumptions regarding reinsurance amounts payable under § 423.329(c) used in calculating the bid.

(iv) The assumptions regarding low-income cost-sharing payable under § 423.329(d) used in calculating the bid.

(v) The amount of administrative costs and return on investment or profit included in the bid.

(3) *Service area.* A description of the service area of the plan.

(4) *Level of risk assumed.* For a potential Part D sponsor, the level of risk assumed in the bid specified in paragraph (e) of this section.

(5) *Plan Average Risk Score.* An estimate of the plan's average prescription drug risk score (as established under § 423.329(b)) for all projected enrollees for purposes of risk adjusting any supplemental premium.

(6) *Additional information.* Additional information CMS requests to support bid amounts and facilitate negotiation.

(e) *Special rule for PDP sponsors.* Bids for all plans offered by a potential PDP sponsor in a region, but not those of potential MA organizations offering MA-PD plans, PACE organizations offering PACE plans including qualified prescription drug coverage, and cost-based HMOs or CMPs offering section 1876 cost plans including qualified pre-

scription 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 percents 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 percents 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)(ii)(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; 76 FR 21573, Apr. 15, 2011; 83 FR 16749, Apr. 16, 2018; 86 FR 6118, Jan. 19, 2021; 88 FR 22339, Apr. 12, 2023; 89 FR 30836, Apr. 23, 2024]

**§ 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(8)(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 PDP sponsor (or by a parent organization to that PDP sponsor) that re-

cently purchased (or otherwise acquired or merged with) another Part D sponsor if it finds that the benefit package or plan costs represented by that bid are substantially different from benefit packages or plan costs represented by another bid submitted by the same Part D sponsor (or parent organization to that Part D sponsor), as provided under § 423.265(b)(2).

(4) CMS may decline to approve a bid if the Part D sponsor proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(c) *Limited risk plans.* (1) Application of limited risk plans. There is no limit on the number of full risk plans that CMS approves under paragraph (b) of this section. CMS approves a limited risk plan in accordance with paragraphs (c)(2) and (c)(3) of this section only if the access requirements under § 423.859 are not otherwise met for a PDP region.

(2) *Maximizing assumption of risk.* CMS gives priority in approval for those limited risk plans bearing the highest level of risk, but may take into account the level of the bids submitted by the plans and is not required to accept the limited risk plan with the highest assumption of risk. In no case does CMS approve a limited risk plan under which the modification of risk level provides for no (or a minimal) level of financial risk.

(3) *Limited exercise of authority.* CMS approves only the minimum number of limited risk plans needed to meet the access requirements.

(d) *Special rules for private fee-for-service (PFFS) plans that offer prescription drug coverage.* PFFS plans (as defined at § 422.4(a)(3)) choosing to offer prescription drug coverage are subject to all MA-PD bid submission and approval requirements applicable to MA-PD plans with the following exceptions:

(1) *Exemption from negotiations.* These plans are exempt from the review and negotiation process in paragraph (a) of this section, and are not held to the revenue requirements standard in paragraph (b)(1) of this section.

(2) *Requirements regarding negotiated prices.* These plans are not required to provide access to negotiated prices. However, if they do, they must meet

the applicable requirements of § 423.104(h).

(3) *Modification of pharmacy access standard and disclosure requirement.* If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost sharing and without regard to whether they are network pharmacies, §§ 423.120(a) and 423.132 requiring certain network access standards and the disclosure of the availability of lower cost bioequivalent generic drugs does not apply to the plan.

(e) *Special rule for plans with standardized bids sufficiently below the national average monthly bid to result in a negative premium.* In the event of a negative premium, as described in § 423.286(d)(1), CMS negotiates the incorporation of the negative premium amount into the bid as either a reduction in the supplemental premium if the Part D plan already submitted a bid with an enhanced alternative benefit, or CMS requires the addition of new enhanced alternative benefit of no less value than the amount of the negative premium.

[70 FR 4525, Jan. 28, 2005, as amended at 75 FR 19819, Apr. 15, 2010; 76 FR 21574, Apr. 15, 2011; 83 FR 16749, Apr. 16, 2018]

**§ 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 of Part D eligible individuals enrolled in a reference month in all Part D plans except MSA plans, fallbacks, 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.

(2) For purposes of calculating the monthly national average monthly bid amount for 2006, CMS assigns equal weighting to PDP sponsors (other than fallback entities) and assigns MA-PD plans included in the national average bid a weight based on prior enrollment (new MA-PD plans are assigned zero weight).

(c) *Geographic adjustment.* (1) Upon the development of an appropriate methodology, the national average monthly bid amount for Part D plans will be adjusted to take into account differences in prices for Part D drugs among PDP regions.

(2) CMS does not apply any geographic adjustments if CMS determines that price variations among PDP regions are negligible.

(3) CMS applies any geographic adjustment in a budget neutral manner so as to not result in a change in the aggregate payments that may have been made if CMS had not applied an adjustment.

(4) CMS does not apply any geographic adjustment until an appropriate methodology is developed.

**§ 423.286 Rules regarding premiums.**

(a) *General rule.* Except as provided in paragraphs (d)(3), (d)(4), and (e) of this section, and with regard to employer group waivers, the monthly beneficiary premium for a Part D plan in a PDP region is the same for all Part D eligible individuals enrolled in the plan. The monthly beneficiary premium for a Part D plan is the base beneficiary premium, as determined in paragraph (c) of this section, adjusted as described in paragraph (d) of this section for the difference between the bid and the national average monthly bid amount,

any supplemental benefits and for any late enrollment penalties.

(b) *Beneficiary premium percentage.* The beneficiary premium percentage for any year is a fraction, the—

(1) Numerator of which is 25.5 percent; and

(2) Denominator of which is as follows:

(i) 100 percent minus the percentage established in paragraph (b)(2)(ii) of this section.

(ii) The percentage established in this paragraph equals:

(A) The total reinsurance payments that CMS estimates will be paid under § 423.329(c) for the coverage year; divided by—

(B) The amount estimated under paragraph (b)(2)(ii)(A) of this section for the year plus total payments that CMS estimates will be paid to Part D plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by both CMS and enrollees.

(c) *Base beneficiary premium.* The base beneficiary premium for a Part D plan for a month is equal to the product of the—

(1) Beneficiary premium percentage as specified in paragraph (b) of this section; and

(2) National average monthly bid amount (computed under § 423.279) for the month.

(d) *Adjustments to base beneficiary premium.* The base beneficiary premium may be adjusted to reflect any of the following scenarios, if applicable.

(1) *Adjustment to reflect difference between bid and national average bid.* If the amount of the standardized bid amount exceeds the adjusted national average monthly bid amount, the monthly base beneficiary premium is increased by the amount of the excess. If the amount of the adjusted national average monthly bid amount exceeds the standardized bid amount, the monthly base beneficiary premium is decreased by the amount of the excess. If the amount of the adjusted national average monthly bid amount exceeds the standardized bid amount by an amount greater than the base beneficiary premium and results in a negative premium, then the beneficiary premium is zero, and the excess amount is

applied to supplemental Part D benefits as described in § 423.272(e).

(2) *Increase for supplemental prescription drug benefits.* The portion of the Part D plan approved bid that is attributable to supplemental prescription drug benefits increases the beneficiary premium. This supplemental portion of the bid may be adjusted to reflect the average risk of enrollees in the plan as determined based on negotiations between CMS and the Part D sponsor offering the plan.

(3) *Increase for late enrollment penalty.* The base beneficiary premium for a Part D enrollee subject to the late enrollment penalty is increased by the amount of any late enrollment penalty.

(i) *Late enrollment penalty amount.* The penalty amount for a Part D eligible individual for a continuous period of eligibility (as provided in § 423.46(a)) is the greater of—

(A) An amount that CMS determines is actuarially sound for each uncovered month in the same continuous period of eligibility; or

(B) 1 percent of the base beneficiary premium (computed under paragraph (c) of this section) for each uncovered month in the period.

(ii) *Special rule for 2006 and 2007.* In 2006 and 2007 the penalty amount discussed in paragraph (d)(3) of this chapter equals the amount referenced in paragraph (d)(3)(i)(B) of this section unless another amount is specified in a separate issuance based on available analysis or other information as determined by the Secretary.

(4) *Increase for income-related monthly adjustment amount (Part D—IRMAA).* Beginning January 1, 2011, Medicare beneficiaries enrolled in a Medicare Part D plan must pay an income-related monthly adjustment amount in addition to the Part D premium as determined under paragraph (c) of this section and adjusted under paragraph (d) of this section, if the enrollee's modified adjusted gross income exceeds the threshold amounts specified in 20 CFR 418.2115.

(i) *Social Security Administration determination.* (A) SSA determines which Part D enrollees are subject to the Part D—IRMAA and the amount each enrollee will have to pay.

(B) If an individual disagrees with SSA's determination that such individual is subject to the Part D—IRMAA, or about the amount the individual must pay, an individual may file an appeal or request a new initial determination consistent with 20 CFR part 418.

(ii) *Calculating the income-related monthly adjustment amount.* The income-related monthly adjustment is equal to the product of the standard base beneficiary premium, as determined under paragraph (c) of this section, and the ratio of the applicable premium percentage specified in 20 CFR 418.2120, reduced by 25.5 percent; divided by 25.5 percent (that is, premium percentage – 25.5 percent)/25.5 percent).

(e) *Decrease in monthly beneficiary premium for low-income assistance.* The monthly beneficiary premium may be eliminated or decreased in the case of a subsidy-eligible individual under § 423.780.

(f) *Special rules for fallback prescription drug plans.* The monthly beneficiary premium charged under a fallback prescription drug plan is calculated under § 423.867(a) and not under this section, except that enrollees in fallback prescription drug plans are subject to late enrollment penalties under paragraph (d)(3) of this section and fallback prescription drug plan premiums are reduced or eliminated in the case of a subsidy-eligible individual, as described in paragraph (e) of this section.

[70 FR 4525, Jan. 28, 2005, as amended at 76 FR 21574, Apr. 15, 2011; 86 FR 6118, Jan. 19, 2021]

**§ 423.293 Collection of monthly beneficiary premium.**

(a) *General rules.* Part D sponsors must—

(1) Charge enrollees a consolidated monthly Part D premium equal to the sum of the Part D monthly premium for basic prescription drug coverage (if any) and the premium for supplemental coverage (if any and if the beneficiary has enrolled in such supplemental coverage).

(2) Permit payment of monthly Part D premiums (if any) under the timing of payments established in § 422.262(e) of this chapter; and

(3) Permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the sponsor using any of the methods listed in § 422.262(f) of this chapter.

(4) *Retroactive collection of premiums.* In circumstances where retroactive collection of premium amounts is necessary and the enrollee is without fault in creating the premium arrearage, the Part D sponsor shall offer the enrollee the option of payment by lump sum, by equal monthly installment spread out over at least the same period for which the premiums were due, or through other arrangements mutually acceptable to the enrollee and the Part D sponsor. For monthly installments, for example, if 7 months of premiums are due, the member would have at least 7 months to repay.

(b) *Crediting of late enrollment penalty.* CMS estimates and specifies the portion of the late enrollment penalty imposed under § 423.286(d)(3) attributable to increased actuarial costs assumed by the Part D sponsor and not taken into account through risk adjustment provided under § 423.329(b)(1) or through reinsurance payments under § 423.329(c) as a result of the late enrollment.

(c) *Collection of late enrollment penalty—(1) Collection through withholding.* In the case of a late enrollment penalty that is collected by the government from a Part D eligible individual in the manner described in § 422.262(f)(1) of this chapter, CMS pays only the portion of the late enrollment penalty described in paragraph (b) of this section to the Part D sponsor offering the Part D plan in which the individual is enrolled.

(2) *Collection by plan.* In the case of a late enrollment penalty collected from a Part D eligible individual in a manner other than the manner described in § 422.262(f)(1) of this chapter, CMS reduces payments otherwise made to the Part D plan by an amount equal to the portion of the late enrollment penalty.

(d) *Collection of the income-related monthly adjustment amount (Part D—IRMAA).* (1) *Collection through withholding.* Where the Social Security Administration has determined the income-related monthly adjustment amount for an individual whose income



exceeds the income threshold amounts specified at 20 CFR 418.2115, the Part 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 must be billed directly for the Part D—IRMAA. 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.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20506, Apr. 15, 2008; 74 FR 1544, Jan. 12, 2009; 76 FR 21574, Apr. 15, 2011; 89 FR 30836, Apr. 23, 2024]

**§ 423.294 Failure to collect and incorrect collections of premiums and cost sharing.**

(a) *Requirement to collect premiums and cost sharing.* A Part D sponsor violates the uniform benefit provisions at § 423.104(b) if it fails to collect or incorrectly collects applicable cost sharing, or fails to collect or incorrectly col-

lects premiums as required by § 422.262(e) of this chapter—

(1) In accordance with the timing of premium payments;

(2) At the time a drug is dispensed; or

(3) By billing the enrollee or another appropriate party after the fact.

(b) Refunds of incorrect collections—  
(1) *Definitions.* As used in this section the following definitions are applicable:

*Amounts incorrectly collected.* (A) Means amounts that exceed the monthly Part D enrollee premium limits under § 423.286 or exceed permissible cost-sharing or copayment amounts as specified in § 423.104(d) through (f), whether paid by or on behalf of the enrollee;

(B) Includes amounts collected with respect to an enrollee who was believed to be entitled to Medicare benefits but was later found not to be entitled; and

(C) Excludes de minimis amounts, as calculated per PDE transaction or per monthly premium billing.

*De minimis amounts* means an amount per PDE transaction for claims adjustments and per month for premium adjustments that does not exceed the de minimis amount determined for purposes of § 423.34(c)(2).

*Other amounts due* means amounts due to affected enrollees or others on their behalf (other than de minimis amounts) for covered Part D drugs that were—

(A) Accessed at an out-of-network pharmacy in accordance with the requirements at § 423.124; or

(B) Initially denied but, upon appeal, found to be covered Part D drugs the enrollee was entitled to have provided by the Part D plan.

(2) *General rule.* A Part D sponsor must make a reasonable effort to identify all amounts incorrectly collected and to pay any other amounts due during the timeframe for coordination of benefits as established at § 423.466(b). A Part D sponsor must issue a refund for an identified enrollee overpayment within the timeframe specified at § 423.466(a).

(3) *Refund methods—(i) Lump-sum payment.* The Part D sponsor must use lump-sum payments for the following:

(A) Amounts incorrectly collected as cost-sharing.