

Actually paid means that the costs must be actually incurred by the qualified retiree prescription drug plan and must be net of any direct or indirect remuneration (including discounts, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers) from any source that would serve to decrease the costs incurred under the qualified retiree prescription drug plan.

Administrative costs means costs incurred by a qualified retiree prescription drug plan that are not drug costs incurred to purchase or reimburse the purchase of Part D drugs.

Allowable retiree costs means the subset of gross covered retiree plan-related prescription drug costs actually paid by the sponsor of the qualified retiree prescription drug plan or by (or on behalf of) a qualifying covered retiree under the plan.

Benefit option means a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

Employment-based retiree health coverage means coverage of health care costs under a group health plan based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. The term includes coverage provided by voluntary insurance coverage, or coverage as a result of a statutory or contractual obligation.

Gross covered retiree plan-related prescription drug costs, or *gross retiree costs*, means those Part D drug costs incurred under a qualified retiree prescription drug plan, excluding administrative costs, but including dispensing fees, during the coverage year. They equal the sum of the following:

(1) The share of prices paid by the qualified retiree prescription drug plan that is received as reimbursement by the pharmacy or by an intermediary contracting organization, and reimbursement paid to indemnify a qualifying covered retiree when the reimbursement is associated with a qualifying covered retiree obtaining Part D

drugs under the qualified retiree prescription drug plan.

(2) All amounts paid under the qualified retiree prescription drug plan by or on behalf of a qualifying covered retiree (such as the deductible, coinsurance, or cost sharing) in order to obtain Part D drugs that are covered under the qualified retiree prescription drug plan.

Group health plans include plans as defined in section 607(1) of ERISA, 29 U.S.C. §1167(1). They also include the following plans:

(1) A Federal or State governmental plan, which is a plan providing medical care that is established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision of a State (including a county or local government), or by any agency or instrumentality or any of the foregoing, including a health benefits plan offered under chapter 89 of Title 5, United States Code (the Federal Employee Health Benefit Plan (FEHBP)).

(2) A collectively bargained plan, which is a plan providing medical care that is established or maintained under or by one or more collective bargaining agreements.

(3) A church plan, which is a plan providing medical care that is established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches that is exempt from tax under section 501 of the Internal Revenue Code of 1986 (26 U.S.C. 501).

(4) An account-based medical plan such as a Health Reimbursement Arrangement (HRA) as defined in Internal Revenue Service Notice 2002-45, 2002-28 I.R.B. 93, a health Flexible Spending Arrangement (FSA) as defined in Internal Revenue Code (Code) section 106(c)(2), a health savings account (HSA) as defined in Code section 223, or an Archer MSA as defined in Code section 220, to the extent they are subject to ERISA as employee welfare benefit plans providing medical care (or would be subject to ERISA but for the exclusion in ERISA section 4(b), 29 U.S.C. §1003(b), for governmental plans or church plans).

Part D drug is defined in § 423.100 of this part.

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Part D eligible individual is defined in § 423.4 of this part.

Qualified retiree prescription drug plan means employment-based retiree health coverage that meets the requirements set forth in § 423.884 of this chapter for a Part D eligible individual who is a retired participant or the spouse or dependent of a retired participant under the coverage.

Qualifying covered retiree means a Part D eligible individual who is: a participant or the spouse or dependent of a participant; covered under employment-based retiree health coverage that qualifies as a qualified retiree prescription drug plan; and not enrolled in a Part D plan. For this purpose, the determination of whether an individual is covered under employment-based retiree health coverage is made by the sponsor in accordance with the rules of its plan. For purposes of this subpart, however, an individual is presumed not to be covered under employment-based retiree health coverage if, under the Medicare Secondary Payer rules in § 411.104 of this chapter and related CMS guidance, the person is considered to be receiving coverage by reason of current employment status. The presumption applies whether or not the Medicare Secondary Payer rules actually apply to the sponsor. For this purpose, a sponsor also may treat a person receiving coverage under its qualified retiree prescription drug plan as the dependent of a qualifying covered retiree in accordance with the rules of its plan, regardless of whether that person constitutes the qualifying covered retiree's dependent for Federal or State tax purposes.

Retiree drug subsidy amount, or subsidy payment, means the subsidy amount paid to sponsors of qualified retiree prescription drug coverage under § 423.886(a).

Standard prescription drug coverage is defined in § 423.100 of this part.

Sponsor is a plan sponsor as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(16)(B), except that, in the case of a plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of financing, the term means the employer.

Sponsor agreement means an agreement by the sponsor to comply with the provisions of this subpart.

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1549, Jan. 12, 2009; 77 FR 1883, Jan. 12, 2012]

§ 423.884 Requirements for qualified retiree prescription drug plans.

(a) *General.* Employment-based retiree health coverage is considered to be a qualified retiree prescription drug plan if all of the following requirements are satisfied:

(1) An actuarial attestation is submitted in accordance with paragraph (d) of this section. The rules for submitting attestations as part of subsidy applications are described in paragraph (c) of this section.

(2) Part D eligible individuals covered under the plan are provided with creditable coverage notices in accordance with § 423.56.

(3) Records are maintained and made available for audit in accordance with paragraph (f) of this section and § 423.888(d).

(b) *Disclosure of information.* The sponsor must have a written agreement with its health insurance issuer (as defined in 45 CFR 160.103), or group health plan (as applicable) regarding disclosure of information to CMS, and the issuer or plan must disclose to CMS, on behalf of the sponsor, the information necessary for the sponsor to comply with this subpart.

(c) *Application*—(1) *Submitting an application.* The sponsor (or its designee) must submit an application for the subsidy to CMS that is signed by an authorized representative of the sponsor. The application must be provided in a form and manner specified by CMS.

(2) *Required information.* In connection with each application the sponsor (either directly or through its designee) must submit the following:

(i) Employer Tax ID Number (if applicable).

(ii) Sponsor name and address.

(iii) Contact name and email address.

(iv) Actuarial attestation that satisfies the standards specified in paragraph (d) of this section and any other supporting documentation required by

CMS for each qualified retiree prescription drug plan for which the sponsor seeks subsidy payments.

(v) A list of all individuals the sponsor believes (using information reasonably available to the sponsor when it submits the application) are qualifying covered retirees enrolled in each prescription drug plan (including spouses and dependents, if Medicare-eligible), along with the information about each person listed below in this paragraph:

- (A) Full name.
- (B) Health Insurance Claim (HIC) number or Social Security number.
- (C) Date of birth.
- (D) Gender.
- (E) Relationship to the retired employee.
- (vi) A sponsor may satisfy paragraph (c)(2)(v) of this section by entering into a voluntary data sharing agreement (VDSA) with CMS (or any other arrangement CMS may make available).
- (vii) A signed sponsor agreement.
- (viii) Any other information specified by CMS.

(3) *Terms and conditions.* To receive a subsidy payment, the sponsor (through the signed sponsor agreement or as otherwise specified by CMS) must specifically accept and agree to:

- (i) Comply with the terms and conditions of eligibility for a subsidy payment set forth in this regulation and in any related CMS guidance;
- (ii) Acknowledge that at the same time CMS releases Part C and Part D summary payment data in accordance with §§ 422.504(n) and 423.505(o) CMS will also release Part D retiree drug subsidy payment data for the most recently reconciled year including the name of the eligible sponsor, the total gross aggregate dollar amount of the CMS subsidy, and the number of eligible retirees;
- (iii) Acknowledge that the information in the application is being provided to obtain Federal funds; and
- (iv) Require that all subcontractors, including plan administrators, acknowledge that information provided in connection with the subcontract is used for purposes of obtaining Federal funds.

(4) *Signature by sponsor.* An authorized representative of the requesting sponsor must sign the completed appli-

cation and certify that the information contained in the application is true and accurate to the best of the sponsor's knowledge and belief.

(5) *Timing*—(i) *General rule.* An application for a given plan year must be submitted prior to the beginning of the plan year by a date specified by CMS in published guidance, unless a request for an extension has been filed and approved under procedures set forth in such guidance.

(ii) *Transition rule.* For plan years that end in 2006, an application must be submitted by September 30, 2005 unless a request for an extension has been filed and approved under procedures established by CMS.

(6) *Updates.* The sponsor (or the designee) must provide updates to CMS in a manner specified by CMS of the information required in paragraph (c)(2) of this section on a monthly basis or at a frequency specified by CMS.

(7) *Data match.* Once the full application for the subsidy payment is submitted, CMS—

(i) Matches the names and identifying information for the individuals submitted as qualifying covered retirees with a CMS database(s) to determine which retirees are Part D eligible individuals who are not enrolled in a Part D plan.

(ii) Provides information concerning the results of the search in paragraph (c)(7)(i) of this paragraph (such as names and other identifying information, if necessary) to the sponsor (or to a designee).

(d) *Actuarial attestation—general.* The sponsor of the plan must provide to CMS an attestation in a form and manner specified by CMS that the actuarial value of the retiree prescription drug coverage under the plan is at least equal to the actuarial value of the defined standard prescription coverage (as defined at § 423.100), not taking into account the value of any discount or coverage provided during the coverage gap (as defined at § 423.100). The attestation must meet all of the following standards:

(1) Contents of the attestation include the following assurances:

(i) The actuarial gross value of the retiree prescription drug coverage under the plan for the plan year is at

least equal to the actuarial gross value of the defined standard prescription drug coverage under Part D for the plan year in question, not taking into account the value of any discount or coverage provided during the coverage gap.

(ii) The actuarial net value of the retiree prescription drug coverage under the plan for that plan year is at least equal to the actuarial net value of the defined standard prescription drug coverage under Part D for that plan year in question, not taking into account the value of any discount or coverage provided during the coverage gap.

(iii) The actuarial values must be determined using the methodology in paragraph (d)(5) of this section.

(2) The attestation must be made by a qualified actuary who is a member of the American Academy of Actuaries. Applicants may use qualified outside actuaries, including (but not limited to) actuaries employed by the plan administrator or an insurer providing benefits under the plan. If an applicant uses an outside actuary, the attestation can be submitted directly by the outside actuary or by the plan sponsor.

(3) The attestation must be signed by a qualified actuary and must state that the attestation is true and accurate to the best of the attester's knowledge and belief.

(4) The attestation must contain an acknowledgement that the information being provided in the attestation is being used to obtain Federal funds.

(5) *Methodology*—(i) *Basis of the attestation.* The attestation must be based on generally accepted actuarial principles and any actuarial guidelines established by CMS in this section or in future guidance. To the extent CMS has not provided guidance on a specific aspect of the actuarial equivalence standard under this section, an actuary providing the attestation may rely on any reasonable interpretation of this section and section 1860D–22(a) of the Act consistent with generally accepted actuarial principles in determining actuarial values.

(ii) *Specific rules for determining the actuarial value of the sponsor's retiree prescription drug coverage.* (A) The gross value of coverage under the sponsor's retiree prescription drug plan must be

determined using the actual claims experience and demographic data for Part D eligible individuals who are participants and beneficiaries in the sponsor's plan, provided that sponsors without creditable data due to their size or other factors, may use normative databases as specified by CMS. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified by this paragraph (d)(5)(ii)(A).

(B) The net value of coverage provided under the sponsor's retiree prescription drug plan must be determined by reducing the gross value of such coverage as determined under paragraph (d)(5)(ii)(A) of this section by the expected premiums paid by Part D eligible individuals who are plan participants or their spouses and dependents. For sponsors of plans that charge a single, integrated premium or contribution to their retirees for both prescription drug coverage and other types of medical coverage, the attestation must allocate a portion of the premium/contribution to prescription drug coverage under the sponsor's plan, under any method determined by the sponsor or its actuary.

(iii) *Specific rules for calculating the actuarial value of defined standard prescription drug coverage under Part D.* (A) The gross value of defined standard prescription drug coverage under Part D must be determined using the actual claims experience and demographic data for Part D eligible individuals in the sponsor's plan, provided that sponsors without credible data due to their size or other factors may use normative databases as specified by CMS. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified by this paragraph (d)(5)(iii)(A).

(B) To calculate the net value of defined standard prescription drug coverage under Part D, the gross value of defined standard prescription drug coverage under Part D as determined by paragraph (d)(5)(iii)(A) of this section is reduced by the following amounts:

(1) The monthly beneficiary premiums (as defined in § 423.286) expected to be paid for standard prescription drug coverage; and