

(2) An amount calculated to reflect the impact on the value of defined standard prescription drug coverage of supplemental coverage actually provided by the sponsor. Sponsors may use other actuarial approaches specified by CMS as an alternative to the actuarial valuation specified in this paragraph (d)(5)(iii)(B)(2).

(C) The valuation of defined standard prescription drug coverage for a given plan year is based on the initial coverage limit cost-sharing and out-of-pocket threshold for defined standard prescription drug coverage under Part D in effect at the start of such plan year, not taking into account the value of any discount or coverage provided during the coverage gap.

(D) Example: If a sponsor's retiree prescription drug plan operates under a plan year that ends March 30, the sponsor has a choice of basing the attestation for the year April 1, 2007 through March 30, 2008 on either the initial coverage limit, cost-sharing amounts, and out-of-pocket threshold amounts that apply to defined standard prescription drug coverage under Part D in CY 2007, or the amounts announced for CY 2008. However, in order to use the amounts applicable in CY 2007, the sponsor must submit the attestation within 60 days after the publication of the Part D coverage limits for CY 2008. If the attestation is submitted more than 60 days after the 2008 coverage limits have been published, the CY 2008 coverage limits would apply.

(iv) Employment-based retiree health coverage with two or more benefit options. For the assurance required under paragraph (d)(1)(i) of this section, the assurance must be provided separately for each benefit option for which the sponsor requests a subsidy under this subpart. For the assurance required under paragraph (d)(1)(ii) of this section, the assurance may be provided either separately for each benefit option for which the sponsor provided assurances under paragraph (d)(1)(i) of this section, or in the aggregate for all benefit options (or for a subset of the benefit options).

(6) *Timing*—(i) *Annual submission*. The attestation must be provided annually at the time the sponsor's subsidy application is submitted, or at such other

times as specified by CMS in further guidance.

(ii) Submission following material change. The attestation must be provided no later than 90 days before the implementation of a material change to the drug coverage of the sponsor's retiree prescription drug plan. For purposes of this clause, the term "material change" means the addition of a benefit option that does not impact the actuarial value of the retiree prescription drug coverage under the sponsor's plan such that it no longer meets the standards set forth in paragraph (d)(1)(i) or (ii) of this section.

(7) Notice of failure to continue to satisfy the actuarial equivalence standards. A sponsor must notify CMS, in a form and manner specified by CMS, no later than 90 days before the implementation of a change to the drug coverage that impacts the actuarial value of the retiree prescription drug coverage under the sponsor's plan such that it no longer meets the standards set forth in paragraph (d)(1)(i) or (ii) of this section.

(e) *Disclosure of creditable prescription drug coverage status*. The sponsor must disclose to all of its retirees and their spouses and dependents eligible to participate in its plan who are Part D eligible individuals whether the coverage is creditable prescription drug coverage under § 423.56 in accordance with the notification requirements under that section.

(f) *Access to records for audit*. The sponsor (and where applicable, its designee) must meet the requirements of § 423.888(d). Failure to comply with § 423.888(d) may result in nonpayment or recoupment of all or part of a subsidy payment.

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§ 423.886 Retiree drug subsidy amounts.

(a) *Amount of subsidy payment*. (1) For each qualifying covered retiree enrolled with the sponsor of a qualified retiree prescription drug plan in a plan year, the sponsor receives a subsidy payment in the amount of 28 percent of the allowable retiree costs (as defined

in § 423.882) in the plan year for such retiree attributable to gross retiree costs between the cost threshold and the cost limit as defined in paragraph (b) of this section. The subsidy payment is calculated by first determining gross retiree costs between the cost threshold and cost limit, and then determining allowable retiree costs attributable to the gross retiree costs. For this purpose and where otherwise relevant in this subpart, plan year is the calendar, policy, or fiscal year on which the records of a plan are kept.

(2) *Transition provision.* For a qualified retiree prescription drug plan that has a plan year which begins in calendar year 2005 and ends in calendar year 2006, the subsidy for the plan year must be determined in the following manner. Claims incurred in all months of the plan year (including claims incurred in 2005) are taken into account in determining which claims fall within the cost threshold and cost limit for the plan year. The subsidy amount is determined based only on costs incurred on and after January 1, 2006.

(b) *Cost threshold and cost limit.* The following cost threshold and cost limits apply—

(1) Subject to paragraph (b)(3) of this section, the cost threshold under this section is equal to \$250 for plan years that end in 2006.

(2) Subject to paragraph (b)(3) of this section, the cost limit under this section is equal to \$5,000 for plan years that end in 2006.

(3) The cost threshold and cost limit specified in paragraphs (b)(1) and (b)(2) of this section, for plan years that end in years after 2006, are adjusted in the same manner as the annual Part D deductible and the annual Part D out-of-pocket threshold are adjusted annually under § 423.104(d)(1)(ii) and (d)(5)(iii)(B), respectively.

§ 423.888 Payment methods, including provision of necessary information.

(a) *Basis.* The provisions of § 423.301 through § 423.343, including requirements to provide information necessary to ensure accurate subsidy payments, govern payment under § 423.886 except to the extent the provisions in this section specify otherwise.

(b) *General payment rules.* Payment under § 423.886 is conditioned on provision of accurate information. The information must be submitted, in a form and manner and at the times provided in this paragraph and under other guidance specified by CMS, by the sponsor or its designee.

(1) *Timing.* Payment can be made on a monthly, quarterly or annual basis, as elected by the plansponsor under guidance specified by CMS, unless CMS determines that the options must be restricted because of operational limitations.

(i) *Monthly or quarterly payments.* If the plan sponsor elects for payment on a monthly or quarterly basis, it must provide information described in paragraph (b)(2)(i) of this section on the same monthly or quarterly basis, or at such time as CMS specifies.

(ii) *Annual payments.* If the sponsor elects an annual payment, it must submit to CMS actual rebate and other price concession data within 15 months after the end of the plan year.

(2) *Submission of cost data—*(i) *Monthly or quarterly payments.* If the plan sponsor elects to receive payment on a monthly or quarterly basis, it must submit to CMS, in a manner specified by CMS, the gross covered retiree plan-related prescription drug costs (as defined in § 423.882) incurred for its qualifying covered retirees during the payment period for which it is claiming a subsidy payment and any other data CMS may require. Except as otherwise provided by CMS in future guidance, the sponsor must also submit, using historical data and generally accepted actuarial principles, an estimate of the extent to which its expected allowable retiree costs differs from the gross covered retiree plan-related prescription drug costs, based on expected rebates and other price concessions for the upcoming plan year. The estimate must be used to reduce the periodic payments for the plan year. Final allocation of price concession data must occur after the end of the year under the reconciliation provisions of paragraph (b)(4) of this section

(ii) *Annual payments.* If the plan sponsor elects a one-time final annual payment, it must submit, in a manner specified by CMS, within 15 months, or

within any other longer time limit specified by CMS, after the end of the plan year, the total gross covered retiree plan-related prescription drug costs (as defined in § 423.882) for the plan year for which it is claiming a subsidy payment, actual rebate and other price concession data described in paragraph (b)(1)(ii) of this section, and any other data CMS may require. The alternative is that the sponsor can elect an interim annual payment, in which case it must submit the following to CMS, at a time and in a manner specified by CMS: the gross covered retiree plan-related prescription drug costs (as defined in § 423.882) incurred for all of its qualifying covered retirees during the payment period for which it is claiming a subsidy payment; an estimate (using historical data and generally accepted actuarial principles) of the difference between such gross costs and allowable costs (based on expected rebates and other price concessions for the upcoming plan year); and any other data CMS may require.

(3) *Payment by CMS.* CMS makes payment after the sponsor's submission of the cost data at a time and in a manner to be specified by CMS.

(4) *Reconciliation.* (i) Sponsors who elect either monthly, quarterly or an interim annual payment must submit to CMS, within 15 months, or within any other longer time limit specified by CMS, after the end of its plan year, the total gross covered retiree plan-related prescription drug costs (as defined in § 423.882), in a manner specified by CMS; actual rebate and other price concession data for the plan year in question; and any other data CMS may require.

(ii) Upon receiving this data, CMS adjusts the payments made for the plan year in question in a manner to be specified by CMS.

(5) *Special rule for insured plans—(i) Interim payments.* Sponsors of group health plans that provide benefits through health insurance coverage (as defined in 45 CFR 144.103) and that choose either monthly payments, quarterly payments or an interim annual payment in paragraphs (b)(1) and (b)(2) of this section, may elect to determine gross covered plan-related retiree prescription drug costs for purposes of the

monthly, quarterly or interim annual payments based on a portion of the premium costs paid by the sponsor (or by the qualifying covered retirees) for coverage of the covered retirees under the group health plan. Premium costs that are determined, using generally accepted actuarial principles, may be attributable to the gross covered plan-related retiree prescription drug costs incurred by the health insurance issuer (as defined in 45 CFR 144.103) for the sponsor's qualifying covered retirees, except that administrative costs and risk charges must be subtracted from the premium.

(ii) *Final payments.* At the end of the plan year, actual gross retiree plan-related prescription drug costs incurred by the insurer (or the retiree), and the allowable costs attributable to the gross costs, are determined for each of the sponsor's qualifying covered retirees and submitted for reconciliation after the end of the plan year as specified in paragraph (b)(4) of this section. The data for the reconciliation can be submitted directly to CMS by the insurer in a manner to be specified by CMS. Upon receiving this data, CMS adjusts the payments made for the relevant plan year in a manner to be specified by CMS.

(c) *Use of information provided.* Officers, employees and contractors of the Department of Health and Human Services, including the Office of Inspector General (OIG), may use information collected under this section only for the purposes of, and to the extent necessary in, carrying out this subpart including, but not limited to, determination of payments and payment-related oversight and program integrity activities, or as otherwise required by law. This restriction does not limit OIG authority to conduct audits and evaluations necessary for carrying out these regulations.

(d) *Maintenance of records.* (1) The sponsor of the qualified retiree prescription drug plan (or a designee), as applicable, must maintain, and furnish to CMS or the OIG upon request, the records enumerated in paragraph (d)(3) of this section. The records must be maintained for 6 years after the expiration of the plan year in which the costs