

423.894 Construction.

**Subpart S—Special Rules for States-Eligibility Determinations for Subsidies and General Payment Provisions**

423.900 Basis and scope.  
 423.902 Definitions.  
 423.904 Eligibility determinations for low-income subsidies.  
 423.906 General payment provisions.  
 423.907 Treatment of territories.  
 423.908 Phased-down State contribution to drug benefit costs assumed by Medicare.  
 423.910 Requirements.

AUTHORITY: Secs 1102, 1860D-1 through 1860D-42, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395w-101 through 1395w-152, and 1395hh).

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**Subpart A—General Provisions**

**§ 423.1 Basis and scope.**

(a) Basis. (1) This part is based on the indicated provisions of the following sections of the Social Security Act:

1860D-1. Eligibility, enrollment, and information.  
 1860D-2. Prescription drug benefits.  
 1860D-3. Access to a choice of qualified prescription drug coverage.  
 1860D-4. Beneficiary protections for qualified prescription drug coverage.  
 1860D-11. PDP regions; submission of bids; plan approval.  
 1860D-12. Requirements for and contracts with prescription drug plan (PDP) sponsors.  
 1860D-13. Premiums; late enrollment penalty.  
 1860D-14. Premium and cost-sharing subsidies for low-income individuals.  
 1860D-15. Subsidies for Part D eligible individuals for qualified prescription drug coverage.  
 1860D-16. Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.  
 1860D-21. Application to Medicare Advantage program and related managed care programs.  
 1860D-22. Special rules for Employer-Sponsored Programs  
 1860D-23. State pharmaceutical assistance programs.  
 1860D-24. Coordination requirements for plans providing prescription drug coverage.

1860D-31. Medicare prescription drug discount card and transitional assistance program.

1860D-41. Definitions; treatment of references to provisions in Part C.

1860D-42. Miscellaneous provisions.

(2) The following specific sections of the Medicare Modernization Act also address the prescription drug benefit program:

Sec. 102 Medicare Advantage conforming amendments.

Sec. 103 Medicaid amendments.

Sec. 104 Medigap.

Sec. 109 Expanding the work of Medicare Quality Improvement Organizations to include Parts C and D.

(b) *Scope*. This part establishes standards for beneficiary eligibility, access, benefits, protections, and low-income subsidies in Part D, as well as establishes standards and sets forth requirements, limitations, procedures and payments for organizations participating in the Voluntary Medicare Prescription Drug Program.

**§ 423.4 Definitions.**

The following definitions apply to this part, unless the context indicates otherwise:

*Actuarial equivalence* means a state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with section 1860D-11(c) of the Act and with CMS actuarial guidelines.

*Brand name drug* means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(c)), including an application referred to in section 505(b)(2) of the Federal Food, Drug and Cosmetic Act (21 USC 355(b)(2)).

*Cost plan* means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursement contract under section 1876(h) of the Act.

*Eligible fallback entity or fallback entity* is defined at § 423.855.

*Fallback prescription drug plan* is defined at § 423.855.

*Formulary* means the entire list of Part D drugs covered by a Part D plan.

## § 423.6

## 42 CFR Ch. IV (10–1–05 Edition)

*Full-benefit dual eligible individual* has the meaning given the term at § 423.772, except where otherwise provided.

*Generic drug* means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

*Group health plan* is defined at § 423.882.

*Insurance risk* means, for a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitutions, nor does it include elements potentially in the control of the pharmacy (for example, labor costs or productivity).

*MA* stands for Medicare Advantage, which refers to the program authorized under Part C of title XVIII of the Act.

*MA plan* has the meaning given the term in § 422.2 of this chapter.

*MA-PD plan* means an MA plan that provides qualified prescription drug coverage.

*Medicare prescription drug account* means the account created within the Federal Supplementary Medical Insurance Trust Fund for purposes of Medicare Part D.

*Monthly beneficiary premium* means the amount calculated under § 423.286 for Part D plans other than fallback prescription drug plans, and § 423.867(a) for fallback prescription drug plans.

*PACE Plan* means a plan offered by a PACE organization.

*PACE organization* is defined in § 460.6 of this chapter.

*Part D eligible individual* means an individual who meets the requirements at § 423.30(a).

*Part D plan (or Medicare Part D plan)* means a prescription drug plan, an MA-PD plan, a PACE Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

*Part D plan sponsor or Part D sponsor* refers to a PDP sponsor, MA organization offering a MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

*PDP region* means a prescription drug plan region as determined by CMS under § 423.112.

*PDP sponsor* means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part that apply to entities that offer prescription drug plans. This includes fallback entities.

*Prescription drug plan or PDP* means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in § 423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K of this part. This includes fallback prescription drug plans.

*Service area (Service area does not include facilities in which individuals are incarcerated.)* means for—

(1) A prescription drug plan, an area established in § 423.112(a) within which access standards under § 423.120(a) are met;

(2) An MA-PD plan, an area that meets the definition of MA service area as described in § 422.2 of this chapter, and within which access standards under § 423.120(a) are met;

(3) A fallback prescription drug plan, the service area described in § 423.859(b);

(4) A PACE plan offering qualified prescription drug coverage, the service area described in § 460.22 of this chapter; and

(5) A cost plan offering qualified prescription drug coverage, the service area defined in § 417.1 of this chapter.

*Subsidy-eligible individual* means a full subsidy eligible individual (as defined at § 423.772) or other subsidy eligible individual (as defined at § 423.772).

*Tiered cost-sharing* means a process of grouping Part D drugs into different cost sharing levels within a Part D sponsor's formulary.

### **§ 423.6 Cost-sharing in beneficiary education and enrollment-related costs.**

The requirements of section 1857(e)(2) of the Act and § 422.6 of this chapter with regard to the payment of fees established by CMS for cost sharing of enrollment related costs apply to PDP sponsors under Part D.