trative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

(5) Transfer of any remaining balance from Transitional Assistance Account

Any balance in the Transitional Assistance Account that is transferred under section 1395w–141(k)(5) of this title shall be deposited into the Account.

(Aug. 14, 1935, ch. 531, title XVIII, §1860D–16, as added Pub. L. 108–173, title I, §101(a)(2), Dec. 8, 2003, 117 Stat. 2120.)

SUBPART 3—APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND TREATMENT OF EMPLOYER-SPONSORED PROGRAMS AND OTHER PRESCRIPTION DRUG PLANS

§ 1395w–131. Application to Medicare Advantage program and related managed care programs

(a) Special rules relating to offering of qualified prescription drug coverage

(1) In general

An MA organization on and after January 1, 2006—

(A) may not offer an MA plan described in section 1395w–21(a)(2)(A) of this title in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

(i) under an MSA plan; or

(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

(2) Qualifying coverage

For purposes of paragraph (1)(A), the term ''required coverage'' means with respect to an MA–PD plan—

(A) basic prescription drug coverage; or

(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1395w–24(b)(1)(C) of this title).

(b) Application of default enrollment rules

(1) Seamless continuation

In applying section 1395w–21(c)(3)(A)(ii) of this title, an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA–PD plan unless such health benefits plan provides any prescription drug coverage.

(2) MA continuation

In applying section 1395w–21(c)(3)(B) of this title, an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA–PD plan unless—

(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

(B) for periods after January 1, 2006, such MA plan is an MA–PD plan.

(3) Discontinuance of MA–PD election during first year of eligibility

In applying the second sentence of section 1395w–21(e)(4) of this title in the case of an individual who is electing to discontinue enrollment in an MA–PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

(4) Rules regarding enrollees in MA plans not providing qualified prescription drug coverage

In the case of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA–PD plan; and

(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1395ss(s)(3) of this title for purposes of applying such section.

The information disclosed under section 1395w–22(c)(1) of this title for individuals who are enrolled in such an MA plan shall include information regarding such rules.

(c) Application of part D rules for prescription drug coverage

With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

(1) In general

Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA–PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

(2) Waiver

The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions duplicate, or are in conflict with, provisions otherwise applicable to the organization or plan

under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

(3) Treatment of MA owned and operated pharmacies

The Secretary may waive the requirement of section 1395w–104(b)(1)(C) of this title in the case of an MA–PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

(d) Special rules for private fee-for-service plans that offer prescription drug coverage

With respect to an MA plan described in section 1395w–21(a)(2)(C) of this title that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

(1) Requirements regarding negotiated prices

Subsections (a)(1) and (d)(1) of section 1395w–102 of this title and section 1395w–104(b)(2)(A) of this title shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

(2) 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 participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1395w–104 of this title shall not apply to the plan.

(3) Drug utilization management program and medication therapy management program not required

The requirements of subparagraphs (A) and (C) of section 1395w–104(c)(1) of this title shall not apply to the plan.

(4) Application of reinsurance

The Secretary shall determine the amount of reinsurance payments under section 1395w–115(b) of this title using a methodology that—

(A) bases such amount on the Secretary's estimate of the amount of such payments that would be payable if the plan were an MA–PD plan described in section 1395w–21(a)(2)(A)(i) of this title and the previous provisions of this subsection did not apply; and

(B) takes into account the average reinsurance payments made under section 1395w–115(b) of this title for populations of similar risk under MA–PD plans described in such section.

(5) Exemption from risk corridor provisions

The provisions of section 1395w–115(e) of this title shall not apply.

(6) Exemption from negotiations

Subsections (d) and (e)(2)(C) of section 1395w–111 of this title shall not apply and the provisions of section 1395w–24(a)(5)(B) of this title prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1395w–111(d) of this title.

(7) Treatment of incurred costs without regard to formulary

The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan's formulary under section 1395w–102(b)(4)(B)(i) of this title shall not apply insofar as the plan does not utilize a formulary.

(e) Application to reasonable cost reimbursement contractors

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1395mm(h) of this title and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395–21(a)(2)(A)(i) of this title and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

(3) Bids not included in determining national average monthly bid amount

The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

(f) Application to PACE

(1) In general

Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1395eee of this title that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1395w–21(a)(2)(A)(ii) of this title and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

(2) Limitation on enrollment

In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

(3) Bids not included in determining standardized bid amount

The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

(Aug. 14, 1935, ch. 531, title XVIII, § 1860D–21, as added Pub. L. 108–173, title I, § 101(a)(2), Dec. 8, 2003, 117 Stat. 2122.)

§ 1395w–132. Special rules for employer-sponsored programs

(a) Subsidy payment

(1) In general

The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(2) Qualified retiree prescription drug plan defined

For purposes of this subsection, the term ‘‘qualified retiree prescription drug plan’’ means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

(A) Attestation of actuarial equivalence to standard coverage

The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1395w–111(c) of this title) is at least equal to the actuarial value of standard prescription drug coverage, not taking into account the value of any discount or coverage provided during the gap in prescription drug coverage that occurs between the initial coverage limit under section 1395w–102(b)(3) of this title during the year and the out-of-pocket threshold specified in section 1395w–102(b)(4)(B) of this title.

(B) Audits

The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1395w–102(d)(3) of this title shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

(C) Provision of disclosure regarding prescription drug coverage

The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1395w–113(b)(6)(B) of this title.

(3) Employer and union special subsidy amounts

(A) In general

For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree’s gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

(B) Cost threshold and cost limit applicable

(i) In general

Subject to clause (ii)—

(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(ii) Indexing

The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1395w–102(b) of this title.

(C) Definitions

For purposes of this paragraph:

(i) Allowable retiree costs

The term ‘‘allowable retiree costs’’ means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

(ii) Gross covered retiree plan-related prescription drug costs

For purposes of this section, the term ‘‘gross covered retiree plan-related pre-