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bid (as described in § 422.256(c)) less the amount of rebate the MA-PD plan elects to apply, as described at § 422.266(b)(2).

MA monthly supplemental beneficiary premium is the portion of the plan bid attributable to mandatory and/or optional supplemental health care benefits described under § 422.102, less the amount of beneficiary rebate the plan elects to apply to a mandatory supplemental benefit, as described at § 422.266(b)(1).

MA-PD plan means an MA local or regional plan that provides prescription drug coverage under Part D of Title XVIII of the Social Security Act.

Monthly aggregate bid amount means the total monthly plan bid amount for coverage of an MA eligible beneficiary with a nationally average risk profile for the factors described in § 422.308(c), and this amount is comprised of the following:

(1) The unadjusted MA statutory non-drug monthly bid amount for coverage of original Medicare benefits;

(2) The amount for coverage of basic prescription drug benefits under Part D (if any); and

(3) The amount for provision of supplemental health care benefits (if any).

Plan basic cost sharing means cost sharing that would be charged by a plan for benefits under the original Medicare FFS program option before any reductions resulting from mandatory supplemental benefits.

Unadjusted MA area-specific non-drug monthly benchmark amount means, for local MA plans serving one county, the county capitation rate CMS publishes annually, and for local MA plans serving multiple counties it is the weighted average of county rates in a plan's service area, weighted by the plan's projected enrollment per county.

Unadjusted MA region-specific non-drug monthly benchmark amount means, for MA regional plans, the amount described at § 422.258(b).

Unadjusted MA statutory non-drug monthly bid amount means a plan's estimate of its average monthly required revenue to provide coverage of original Medicare benefits to an MA eligible beneficiary with a nationally average risk profile for the risk factors CMS

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applies to payment calculations as set forth at § 422.308(c).

63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

§ 422.254 Submission of bids.

(a) *General rules.* (1) Not later than the first Monday in June, each MA organization must submit to CMS an aggregate monthly bid amount for each MA plan (other than an MSA plan) the organization intends to offer in the upcoming year in the service area (or segment of such an area if permitted under § 422.262(c)(2)) that meets the requirements in paragraph (b) of this section. With each bid submitted, the MA organization must provide the information required in paragraph (c) of this section and, for plans with rebates as described at § 422.266(a), the MA organization must provide the information required in paragraph (d) of this section.

(2) CMS has the authority to determine whether and when it is appropriate to apply the bidding methodology described in this section to ESRD MA enrollees.

(3) If the bid submission described in paragraphs (a)(1) and (2) of this section is not complete, timely, or accurate, CMS has the authority to impose sanctions under subpart O of this part or may choose not to renew the contract.

(b) *Bid requirements.* (1) The monthly aggregate bid amount submitted by an MA organization for each plan is the organization's estimate of the revenue required for the following categories for providing coverage to an MA eligible beneficiary with a national average risk profile for the factors described in § 422.308(c):

(i) The unadjusted MA statutory non-drug monthly bid amount, which is the MA plan's estimated average monthly required revenue for providing benefits under the original Medicare fee-for-service program option (as defined in § 422.252).

(ii) The amount to provide basic prescription drug coverage, if any (defined at section 1860D–2(a)(3) of the Act).

(iii) The amount to provide supplemental health care benefits, if any.

(2) Each bid is for a uniform benefit package for the service area.

(3) Each bid submission must contain all estimated revenue required by the plan, including administrative costs and return on investment.

(4) The bid amount is for plan payments only but must be based on plan assumptions about the amount of revenue required from enrollee cost-sharing. The estimate of plan cost-sharing for the unadjusted MA statutory non-drug monthly bid amount for coverage of original Medicare benefits must reflect the requirement that the level of cost sharing MA plans charge to enrollees must be actuarially equivalent to the level of cost sharing (deductible, copayments, or coinsurance) charged to beneficiaries under the original Medicare program option. The actuarially equivalent level of cost sharing reflected in a regional plan's unadjusted MA statutory non-drug monthly bid amount does not include cost sharing for out-of-network Medicare benefits, as described at § 422.101(d).

(c) *Information required for coordinated care plans and MA private fee-for-service plans.* MA organizations' submission of bids for coordinated care plans, including regional MA plans and specialized MA plans for special needs beneficiaries (described at § 422.4(a)(1)(iv)), and for MA private fee-for-service plans must include the following information:

(1) The plan type for each plan.

(2) The monthly aggregate bid amount for the provision of all items and services under the plan, as defined in § 422.252 and discussed in paragraph (a) of this section.

(3) The proportions of the bid amount attributable to—

(i) The provision of benefits under the original Medicare fee-for-service program option (as defined at § 422.100(c));

(ii) The provision of basic prescription drug coverage (as defined at section 1860D-2(a)(3) of the Act; and

(iii) The provision of supplemental health care benefits (as defined § 422.102).

(4) The projected number of enrollees in each MA local area used in calculation of the bid amount, and the enrollment capacity, if any, for the plan.

(5) The actuarial basis for determining the amount under paragraph

(c)(2) of this section, the proportions under paragraph (c)(3) of this section, the amount under paragraph (b)(4) of this section, and additional information as CMS may require to verify actuarial bases and the projected number of enrollees.

(6) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of the deductibles, coinsurance, and copayments.

(7) For qualified prescription drug coverage, the information required under section 1860D-11(b) of the Act with respect to coverage.

(8) For the purposes of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit the following information developed using the appropriate actuarial bases.

(i) Projected allowable costs (defined in § 422.458(a)).

(ii) The portion of projected allowable costs attributable to administrative expenses incurred in providing these benefits.

(iii) The total projected costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of costs that is attributable to administrative expenses.

(9) For regional plans, as determined by CMS, the relative cost factors for the counties in a plan's service area, for the purposes of adjusting payment under § 422.308(d) for intra-area variations in an MA organization's local payment rates.

(d) *Beneficiary rebate information.* In the case of a plan required to provide a monthly rebate under § 422.266 for a year, the MA organization offering the plan must inform CMS how the plan will distribute the beneficiary rebate among the options described at § 422.266(b).

(e) *Information required for MSA plans.* MA organizations intending to offer MA MSA plans must submit—

(1) The enrollment capacity (if any) for the plan;

(2) The amount of the MSA monthly premium for basic benefits under the original Medicare fee-for-service program option;

(3) The amount of the plan deductible; and

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(4) The amount of the beneficiary supplemental premium, if any.

(f) Separate bids must be submitted for Part A and Part B enrollees and Part B-only enrollees for each MA plan offered.

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§ 422.256 Review, negotiation, and approval of bids.

(a) *Authority.* Subject to paragraphs (a)(2), (d), and (e) of this section, CMS has the authority to review the aggregate bid amounts submitted under § 422.252 and conduct negotiations with MA organizations regarding these bids (including the supplemental benefits) and the proportions of the aggregate bid attributable to basic benefits, supplemental benefits, and prescription drug benefits.

(1) When negotiating bid amounts and proportions, CMS has authority similar to that provided the Director of the Office of Personnel Management for negotiating health benefits plans under 5 U.S.C. chapter 89.

(2) *Noninterference.* (i) In carrying out Parts C and D under this title, CMS may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services.

(ii) CMS may not require a particular price structure for payment under such a contract, with the exception of payments to Federally qualified health centers as set forth at § 422.316.

(b) *Standards of bid review.* Subject to paragraphs (d) and (e) of this section, CMS can only accept bid amounts or proportions described in paragraph (a) of this section if CMS determines the following standards have been met:

(1) The bid amount and proportions are supported by the actuarial bases provided by MA organizations under § 422.254.

(2) The bid amount and proportions reasonably and equitably reflects the plan's estimated revenue requirements for providing the benefits under that plan, as the term revenue requirements is used for purposes of section 1302(8) of the Public Health Service Act.

(3) *Limitation on enrollee cost sharing.* For coordinated care plans (including

regional MA plans and specialized MA plans) and private fee-for-service plans:

(i) The actuarial value of plan basic cost sharing, reduced by any supplemental benefits, may not exceed—

(ii) The actuarial value of deductibles, coinsurance, and copayments that would be applicable for the benefits to individuals entitled to benefits under Part A and enrolled under Part B in the plan's service area with a national average risk profile for the factors described in § 422.308(c) if they were not members of an MA organization for the year, except that cost sharing for non-network Medicare services in a regional MA plan is not counted under the amount described in paragraph (b)(2)(i) of this section.

(c) *Negotiation process.* The negotiation process may include the resubmission of information to allow MA organizations to modify their initial bid submissions to account for the outcome of CMS' regional benchmark calculations required under § 422.258(c) and the outcome of CMS' calculation of the national average monthly bid amount required under section 1860D–13(a)(4) of the Act.

(d) *Exception for private fee-for-service plans.* For private fee-for-service plans defined at § 422.4(a)(3), CMS will not review, negotiate, or approve the bid amount, proportions of the bid, or the amounts of the basic beneficiary premium and supplemental premium.

(e) *Exception for MSA plans.* CMS does not review, negotiate, or approve amounts submitted with respect to MA MSA plans, except to determine that the deductible does not exceed the statutory maximum, defined at § 422.103(d).

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§ 422.258 Calculation of benchmarks.

(a) The term “MA area-specific non-drug monthly benchmark amount” means, for a month in a year:

(1) *For MA local plans with service areas entirely within a single MA local area,* 1/12th of the annual MA capitation rate (described at § 422.306) for the area, adjusted as appropriate for the purpose of risk adjustment.

(2) *For MA local plans with service areas including more than one MA local*