

(3) Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); and 42 U.S.C. 300bb-2.(2)(D)).

(4) In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability.

(5) Imposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.

(6) Charging a Medicare entitled individual higher premiums.

(7) Requiring a Medicare entitled individual to wait longer for coverage to begin.

(8) Paying providers and suppliers less for services furnished to a Medicare beneficiary than for the same services furnished to an enrollee who is not entitled to Medicare.

(9) Providing misleading or incomplete information that would have the effect of inducing a Medicare entitled individual to reject the employer plan, thereby making Medicare the primary payer. An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that, if he or she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.

(10) Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers, instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer.

(11) Refusing to enroll an individual for whom Medicare would be secondary payer, when enrollment is available to similarly situated individuals for

whom Medicare would not be secondary payer.

(b) *Permissible actions.* (1) If a GHP or LGHP makes benefit distinctions among various categories of individuals (distinctions unrelated to the fact that the individual is disabled, based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP may make the same distinctions among the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are *not* entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who *are* entitled to Medicare on the basis of disability or age.

(2) A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he or she has current employment status, the GHP coverage is by virtue of the COBRA law rather than by virtue of the current employment status.

(3) A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD, when permitted under the COBRA provisions.

[60 FR 45362, Aug. 31, 1995; 60 FR 53876, Oct. 18, 1995]

§411.110 Basis for determination of nonconformance.

(a) A “determination of nonconformance” is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section.

(b) CMS makes a determination of nonconformance for a GHP or LGHP that, at any time during a calendar year, fails to comply with any of the following statutory provisions:

(1) The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the

§ 411.112

basis of ESRD, age, or disability, or eligible on the basis of ESRD.

(2) The nondifferentiation clause for individuals with ESRD.

(3) The equal benefits clause for the working aged.

(4) The obligation to refund conditional Medicare primary payments.

(c) CMS may make a determination of nonconformance for a GHP or LGHP that fails to respond to a request for information, or to provide correct information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary, if that failure contributes to either or both of the following:

(1) Medicare erroneously making a primary payment.

(2) A delay or foreclosure of CMS's ability to recover an erroneous primary payment.

§ 411.112 Documentation of conformance.

(a) *Acceptable documentation.* CMS may require a GHP or LGHP to demonstrate that it has complied with the Medicare secondary payer provisions and to submit supporting documentation by an official authorized to act on behalf of the entity, under penalty of perjury. The following are examples of documentation that may be acceptable:

(1) A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability as compared to the provisions applicable to other enrollees and potential enrollees.

(2) An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as repayment for conditional or mistaken Medicare primary payments.

(b) *Lack of acceptable documentation.* If a GHP or LGHP fails to provide acceptable evidence or documentation that it has complied with the MSP prohibitions and requirements set forth in § 411.110, CMS may make a determination of nonconformance for both the year in which the services were furnished and the year in which the request for information was made.

42 CFR Ch. IV (10–1–23 Edition)

§ 411.114 Determination of nonconformance.

(a) *Starting dates for determination of nonconformance.* CMS's authority to determine nonconformance of GHPs begins on the following dates:

(1) On January 1, 1987 for MSP provisions that affect the disabled.

(2) On December 20, 1989 for MSP provisions that affect ESRD beneficiaries and the working aged.

(3) On August 10, 1993 for failure to refund mistaken Medicare primary payments.

(b) *Special rule for failure to repay.* A GHP that fails to comply with § 411.110 (a)(1), (a)(2), or (a)(3) in a particular year is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments (in accordance with § 411.110(a)(4)), the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 1991, that plan was nonconforming for 1991. If in 1994 CMS identifies mistaken primary payments attributable to the 1991 violation, and the plan refuses to repay, it is also nonconforming for 1994.

§ 411.115 Notice of determination of nonconformance.

(a) *Notice to the GHP or LGHP.* (1) If CMS determines that a GHP or an LGHP is nonconforming with respect to a particular calendar year, CMS mails to the plan written notice of the following:

(i) The determination.

(ii) The basis for the determination.

(iii) The right of the parties to request a hearing.

(iv) An explanation of the procedure for requesting a hearing.

(v) The tax that may be assessed by the IRS in accordance with section 5000 of the IRC.

(vi) The fact that if none of the parties requests a hearing within 65 days from the date of its notice, the determination is binding on all parties unless it is reopened in accordance with § 411.126.

(2) The notice also states that the plan must, within 30 days from the date on its notice, submit to CMS the names and addresses of all employers