

(b) *Application.* The restriction on payments for services imposed by paragraph (a) of this section applies to services received by—

- (1) New Medicare enrollees;
- (2) Nonrisk Medicare enrollees who convert to risk reimbursement; and
- (3) Nonrisk Medicare enrollees who elect special supplemental benefit plans.

(c) *End of restriction.* The restriction of payments imposed by paragraph (a) of this section ends when a Medicare enrollee leaves the HMO's or CMP's geographic area for an extended period as defined in § 417.460(a)(2) and the HMO or CMP and the enrollee make arrangements for enrollment to continue as provided in § 417.460(a)(2)(iv).

(d) *Timing.* The effective date for the end of the restriction on payments, as discussed in paragraph (c) of this section is the first day of the first month following the month in which the enrollee notifies the HMO or CMP as required in § 417.436(a)(9), that he or she has left the HMO's or CMP's geographic area for an extended period.

[51 FR 28573, Aug. 8, 1986, as amended at 56 FR 46571, Sept. 13, 1991; 58 FR 38079, July 15, 1993]

§ 417.450 Effective date of coverage.

(a) *Basic rules.* Except as specified in paragraph (b) of this section, and notwithstanding the provisions of § 417.440(d).

(1) CMS's liability for payments to an HMO or CMP on behalf of a Medicare beneficiary begins on the first day of the month in which he or she is—

- (i) Entitled to Medicare benefits; and
- (ii) Enrolled in an HMO or CMP; and

(2) The effective month of coverage may not be earlier than the first month after, nor later than the third month after the month in which CMS receives the information necessary to include the beneficiary as a Medicare enrollee of the HMO or CMP in CMS records.

(b) *Exceptions.* (1) CMS may approve a later month if it is requested by the HMO or CMP and the beneficiary.

(2) If an individual becomes an HMO or CMP enrollee before becoming entitled to Medicare Part B benefits, the effective month of coverage is the first

month for which he or she becomes entitled to Medicare Part B benefits.

(c) *Notice of effective date of coverage.* For each beneficiary added to CMS's records as an enrollee of an HMO or CMP, CMS gives the HMO or CMP prompt written notice of the month with which CMS's liability begins.

[50 FR 1346, Jan. 10, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.452 Liability of Medicare enrollees.

(a) *Deductibles and coinsurance.* (1) A Medicare enrollee of an HMO or CMP is responsible for applicable Medicare deductible and coinsurance amounts, unless the HMO's or CMP's charges for these amounts are reduced under the additional benefits provision of § 417.442.

(2) The deductible and coinsurance amounts may be paid by or on behalf of the enrollee in the form of a premium, membership fee, charge per unit, or other similar charge.

(3) The sum of the amounts the HMO or CMP charges its Medicare enrollees for Medicare deductibles and coinsurance may not exceed, on the average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in the HMO or CMP or in another HMO or CMP.

(b) *Services not covered under Medicare.* Unless the services are provided as additional benefits under § 417.442, a Medicare enrollee of an HMO or CMP is liable for payment for—

(1) All services that are not covered under Medicare Part A or Part B; or

(2) If entitled only to Medicare Part B benefits, all services that are not covered under Medicare Part B.

(c) *Services for which Medicare is not primary payer.* A Medicare enrollee of an HMO or CMP is liable for payments made to the enrollee for all covered services for which Medicare is not the primary payer as provided in § 417.528.

(d) *Optional supplemental benefits plan.*

(1) The HMO or CMP may offer its Medicare enrollees a supplemental benefit plan to cover deductible and coinsurance amounts, or services not covered under Medicare, or both.

(2) If a supplemental benefit plan premium includes charges for both non-covered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium that is for deductibles and coinsurance must be computed separately and must be disclosed to the beneficiary during the enrollment process and before he or she elects coverage options.

(3) The sum of the amounts an HMO or CMP charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.

(e) *Coverage of Part A services for Part B-only Medicare enrollees.* If an HMO or CMP furnishes coverage of Medicare Part A services to a Medicare enrollee entitled to Part B only, the HMO's or CMP's premium (or other payment method) for these services may not exceed the ACR for these services. In addition, if a risk HMO or CMP furnishes these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the HMO or CMP who are entitled to benefits under both Parts A and B, the HMO's or CMP's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollee of the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.454 Charges to Medicare enrollees.

(a) *Limits on charges.* The HMO or CMP must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) *Limit on charges for inpatient hospital care.* If a Medicare enrollee who is an inpatient of a hospital requests im-

mediate QIO review (as provided in § 417.605) of any determination by the hospital furnishing services or the HMO or CMP that the inpatient hospital services will no longer be covered, the HMO or CMP may not charge the enrollee for any inpatient care costs incurred before noon of the first working day after the QIO issues its review decision.

(c) *Reporting requirements.* A risk HMO or CMP must report, within 90 days after the end of the contract period, all premiums, enrollment fees, and other charges collected from its Medicare enrollees during that period.

(d) *Limit on charges for specified preventive services.* An HMO may not charge deductibles, copayments, or coinsurance for in-network Medicare-covered preventive services (as defined in § 410.152(1)).

(e) *Services for which cost sharing may not exceed cost sharing under original Medicare.* On an annual basis, CMS will evaluate whether there are service categories for which HMOs' cost sharing may not exceed that required under original Medicare and specify in regulation which services are subject to that cost sharing limit. The following services are subject to this limit on cost sharing:

(1) Chemotherapy administration services to include chemotherapy drugs and radiation therapy integral to the treatment regimen.

(2) Renal dialysis services as defined at section 1881(b)(14)(B) of the Act.

(3) Skilled nursing care defined as services provided during a covered stay in a skilled nursing facility during the period for which cost sharing would apply under Original Medicare.

(4) A COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995; 76 FR 21561, Apr. 15, 2011; 85 FR 71197, Nov. 6, 2020; 88 FR 22328, Apr. 12, 2023]

§ 417.456 Refunds to Medicare enrollees.

(a) *Definitions.* As used in this section—

Amounts incorrectly collected means amounts collected that are in excess of