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pay promptly for any reason other than the circumstances described in § 411.32(a)(1). This includes cases in which the no-fault insurance carrier has denied the claim.

(2) The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement stipulated in the policy.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006]

§ 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

(a) *Definition.* As used in this section, *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with § 411.24.

(b) *Applicability.* This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

(c) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(d) *Exception—(1) Prepaid health plans.* If the services were furnished through an organization that has a contact under section 1876 of the Act (that is, an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of § 417.528 of this chapter apply.

(2) *Special rules for Oregon.* For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

(i) The provider or supplier may elect to bill a liability insurer or place a lien against the beneficiary's liability settlement for Medicare covered services, rather than bill only Medicare for Medicare covered services, if the liability

insurer pays within 120 days after the earlier of the following dates:

(A) The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the provider or supplier:

(A) Must withdraw its claim with the liability insurer and/or withdraw its lien against a potential liability settlement.

(B) May only bill Medicare for Medicare covered services.

(C) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under 413.35 of this chapter (when cost limits are applied to these services) or under 489.32 of this chapter (when services are partially covered).

[54 FR 41734, Oct. 11, 1989, as amended at 68 FR 43942, July 25, 2003]

Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions

SOURCE: 60 FR 45362, Aug. 31, 1995, unless otherwise noted.

§ 411.100 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b) of the Act provides in part that Medicare is secondary payer, under specified conditions, for services covered under any of the following:

(i) Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. (Section 1862(b)(1)(A))

(ii) Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in § 411.163, group health plans

are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (Section 1862(b)(1)(C))

(iii) Large group health plans (that is, plans of employers that employ at least 100 employees) and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. (Section 1862(b)(1)(B))

(2) Sections 1862(b)(1)(A), (B), and (C) of the Act provide that group health plans and large group health plans may not take into account that the individuals described in paragraph (a)(1) of this section are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD.

(3) Section 1862(b)(1)(A)(i)(II) of the Act provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under 65. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

(4) Section 1862(b)(1)(C)(ii) of the Act provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute "differentiating" are listed in §411.161(b).

(b) *Scope.* This subpart sets forth general rules pertinent to—

(1) Medicare payment for services that are covered under a group health plan and are furnished to certain beneficiaries who are entitled on the basis of ESRD, age, or disability.

(2) The prohibition against taking into account Medicare entitlement based on age or disability, or Medicare eligibility or entitlement based on ESRD.

(3) The prohibition against differentiation in benefits between individuals

who have ESRD and other individuals covered under the plan.

(4) The requirement to provide to those 65 or over the same benefits under the same conditions as are provided to those under 65.

(5) The appeals procedures for group health plans that CMS determines are nonconforming plans.

§411.101 Definitions.

As used in this subpart and in subparts F through H of this part—

COBRA stands for Consolidated Omnibus Budget Reconciliation Act of 1985.

Days means calendar days.

Employee (subject to the special rules in §411.104) means an individual who—

(1) Is working for an employer; or

(2) Is not working for an employer but is receiving payments that are subject to FICA taxes, or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code.

Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

FICA stands for the Federal Insurance Contributions Act, the law that imposes social security taxes on employers and employees under section 21 of the Internal Revenue Code.

Group health plan (GHP) means any arrangement made by one or more employers or employee organizations to provide health care directly or through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that—

(1) Is of, or contributed to by, one or more employers or employee organizations.

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(2) If it involves more than one employer or employee organization, provides for common administration.

(3) Provides substantially the same benefits or the same benefit options to all those enrolled under the arrangement.

The term includes self-insured plans, plans of governmental entities (Federal, State and local), and employee organization plans; that is, union plans, employee health and welfare funds or other employee organization plans. The term also includes employee-pay-all plans, which are plans under the auspices of one or more employers or employee organizations but which receive no financial contributions from them. The term does not include a plan that is unavailable to employees; for example, a plan only for self-employed persons.

IRC stands for Internal Revenue Code.

IRS stands for Internal Revenue Service.

Large group health plan (LGHP) means a GHP that covers employees of either—

(1) A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

(2) Two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

MSP stands for Medicare secondary payer.

Multi-employer plan means a plan that is sponsored jointly by two or more employers (sometimes called a multiple-employer plan) or by employers and unions (sometimes under the Taft-Hartley law).

Self-employed person encompasses consultants, owners of businesses, and directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

Similarly situated individual means—

(1) In the case of employees, other employees enrolled or seeking to enroll in the plan; and

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(2) In the case of other categories of individuals, other persons in any of those categories who are enrolled or seeking to enroll in the plan.

§ 411.102 Basic prohibitions and requirements.

(a) *ESRD*. (1) A group health plan of any size—(i) May not take into account the ESRD-based Medicare eligibility or entitlement of any individual who is covered or seeks to be covered under the plan; and

(ii) May not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan, on the basis of the existence of ESRD, or the need for dialysis, or in any other manner.

(2) The prohibitions of paragraph (a) of this section do not prohibit a plan from paying benefits secondary to Medicare after the first 18 months of ESRD-based eligibility or entitlement.

(b) *Age*. A GHP of an employer or employee organization of at least 20 employees—

(1) May not take into account the age-based Medicare entitlement of an individual or spouse age 65 or older who is covered (or seeks to be covered) under the plan by virtue of current employment status; and

(2) Must provide, to employees age 65 or older and to spouses age 65 or older of employees of any age, the same benefits under the same conditions as it provides to employees and spouses under age 65.

(c) *Disability*. A GHP of an employer or employee organization of at least 100 employees may not take into account the disability-based Medicare entitlement of any individual who is covered (or seeks to be covered) under the plan by virtue of current employment status.

§ 411.103 Prohibition against financial and other incentives.

(a) *General rule*. An employer or other entity (for example, an insurer) is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a GHP that is, or would be, primary to Medicare. This prohibition precludes offering to Medicare beneficiaries an alternative to the

employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary coverage through his own or a spouse's employer.

(b) *Penalty for violation.* (1) Any entity that violates the prohibition of paragraph (a) of this section is subject to a civil money penalty of up to \$5,000 as adjusted annually under 45 CFR part 102 for each violation; and

(2) The provisions of section 1128A of the Act (other than subsections (a) and (b)) apply to the civil money penalty of up to \$5,000 as adjusted annually under 45 CFR part 102 in the same manner as the provisions apply to a penalty or proceeding under section 1128A(a).

[60 FR 45362, Aug. 31, 1995, as amended at 81 FR 61561, Sept. 6, 2016]

§ 411.104 Current employment status.

(a) *General rule.* An individual has current employment status if—

(1) The individual is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or

(2) The individual is not actively working and—

(i) Is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or

(ii) Retains employment rights in the industry and has not had his employment terminated by the employer, if the employer provides the coverage (or has not had his membership in the employee organization terminated, if the employee organization provides the coverage), is not receiving disability benefits from an employer for more than 6 months, is not receiving disability benefits from Social Security, and has GHP coverage that is not pursuant to COBRA continuation coverage (26 U.S.C. 4980B; 29 U.S.C. 1161–1168; 42 U.S.C. 300bb–1 et seq.). Whether or not the individual is receiving pay during the period of nonwork is not a factor.

(b) *Persons who retain employment rights.* For purposes of paragraph (a)(2) of this section, persons who retain employment rights include but are not limited to—

(1) Persons who are furloughed, temporarily laid off, or who are on sick leave;

(2) Teachers and seasonal workers who normally do not work throughout the year; and

(3) Persons who have health coverage that extends beyond or between active employment periods; for example, based on an hours bank arrangement. (Active union members often have hours bank coverage.)

(c) *Coverage by virtue of current employment status.* An individual has coverage by virtue of current employment status with an employer if—

(1) the individual has GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

(2) the individual has current employment status with that employer, as defined in paragraph (a) of this section.

(d) *Special rule: Self-employed person.* A self-employed individual is considered to have GHP or LGHP coverage by virtue of current employment status during a particular tax year only if, during the preceding tax year, the individual's net earnings, from work in that year related to the employer that offers the group health coverage, are at least equal to the amount specified in section 211(b)(2) of the Act, which defines "self-employment income" for social security purposes.

(e) *Special Rule: members of religious orders and members of clergy—*(1) *Members of religious orders who have not taken a vow of poverty.* A member of a religious order who has not taken a vow of poverty is considered to have current employment status with the religious order if—

(i) The religious order pays FICA taxes on behalf of that member; or

(ii) The individual is receiving cash remuneration from the religious order.

(2) *Members of religious orders who have taken a vow of poverty.* A member of a religious order whose members are required to take a vow of poverty is not considered to be employed by the order if the services he or she performs

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as a member of the order are considered employment only because the order elects social security coverage under section 3121(r) of the IRC. This exemption applies retroactively to services performed as a member of the order, beginning with the effective dates of the MSP provisions for the aged and the disabled, respectively. The exemption does not apply to services performed for employers outside of the order.

(3) *Members of the clergy.* A member of the clergy is considered to have current employment status with a church or other religious organization if the individual is receiving cash remuneration from the church or other religious organization for services rendered.

(f) *Special rule: Delayed compensation subject to FICA taxes.* An individual who is not working is not considered an employee solely on the basis of receiving delayed compensation payments for previous periods of work even if those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working in 1993 and receives payments subject to FICA taxes for work performed in 1992 is not considered to be an employee in 1993 solely on the basis of receiving those payments.

§ 411.106 Aggregation rules.

The following rules apply in determining the number and size of employers, as required by the MSP provisions for the aged and disabled:

(a) All employers that are treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code (IRC) of 1986 (26 U.S.C. 52 (a) and (b)) are treated as a single employer.

(b) All employees of the members of an affiliated service group (as defined in section 414(m) of the IRC (26 U.S.C. 414(m))) are treated as employed by a single employer.

(c) Leased employees (as defined in section 414(n)(2) of the IRC (26 U.S.C. 414(n)(2))) are treated as employees of the person for whom they perform services to the same extent as they are treated under section 414(n) of the IRC.

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(d) In applying the IRC provisions identified in this section, CMS relies upon regulations and decisions of the Secretary of the Treasury respecting those provisions.

§ 411.108 Taking into account entitlement to Medicare.

(a) *Examples of actions that constitute “taking into account”.* Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

(1) Failure to pay primary benefits as required by subparts F, G, and H of this part 411.

(2) Offering coverage that is secondary to Medicare to individuals entitled to Medicare.

(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 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

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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.

§ 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 and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

(b) *Notice to contributing employers and employee organizations.* CMS mails written notice of the determination, including all the information specified in paragraph (a)(1) of this section, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with paragraph (a)(2) of this section. Employers and employee organizations have 65 days from the date of their notice to request a hearing.

§ 411.120 Appeals.

(a) *Parties to the determination.* The parties to the determination are CMS, the GHP or LGHP for which CMS determined nonconformance, and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.

(b) *Request for hearing.* (1) A party's request for hearing must be in writing (not in facsimile or other electronic medium) and in the manner stipulated in the notice of nonconformance; it must be filed within 65 days from the date on the notice.

(2) The request may include rationale showing why the parties believe that CMS's determination is incorrect and supporting documentation.

(3) A request is considered filed on the date it is received by the appropriate office, as shown by the receipt date stamped on the request.

§411.121 Hearing procedures.

(a) *Nature of hearing.* (1) If any of the parties requests a hearing within 65 days from the date on the notice of the determination of nonconformance, the CMS Administrator appoints a hearing officer.

(2) If no party files a request within the 65-day period, the initial determination of nonconformance is binding upon all parties unless it is reopened in accordance with §411.126.

(3) If more than one party requests a hearing the hearing officer conducts a single hearing in which all parties may participate.

(4) *On the record review.* Ordinarily, the hearing officer makes a decision based upon review of the data and documents on which CMS based its determination of nonconformance and any other documentation submitted by any of the parties within 65 days from the date on the notice.

(5) *Oral hearing.* The hearing officer may provide for an oral hearing either on his or her own motion or in response to a party's request if the party demonstrates to the hearing officer's satisfaction that an oral hearing is necessary. Within 30 days of receipt of the request, the hearing officer gives all known parties written notice of the request and whether the request for oral hearing is granted.

(b) *Notice of time and place of oral hearing.* If the hearing officer provides an oral hearing, he or she gives all known parties written notice of the time and place of the hearing at least 30 days before the scheduled date.

(c) *Prehearing discovery.* (1) The hearing officer may permit prehearing discovery if it is requested by a party at least 10 days before the scheduled date of the hearing.

(2) If the hearing officer approves the request, he or she—

(i) Provides a reasonable time for inspection and reproduction of documents; and

(ii) In ruling on discovery matters, is guided by the Federal Rules of Civil Procedure. (28 U.S.C.A. Rules 26–37)

(3) The hearing officer's orders on all discovery matters are final.

(d) *Conduct of hearing.* The hearing officer determines the conduct of the hearing, including the order in which the evidence and the allegations are presented.

(e) *Evidence at hearing.* (1) The hearing officer inquires into the matters at issue and may receive from all parties documentary and other evidence that is pertinent and material, including the testimony of witnesses, and evidence that would be inadmissible in a court of law.

(2) Evidence may be received at any time before the conclusion of the hearing.

(3) The hearing officer gives the parties opportunity for submission and consideration of evidence and arguments and, in ruling on the admissibility of evidence, excludes irrelevant, immaterial, or unduly repetitious evidence.

(4) The hearing officer's ruling on admissibility of evidence is final and not subject to further review.

(f) *Subpoenas.* (1) The hearing officer may, either on his or her own motion or upon the request of any party, issue subpoenas for either or both of the following if they are reasonably necessary for full presentation of the case:

(i) The attendance and testimony of witnesses.

(ii) The production of books, records, correspondence, papers, or other documents that are relevant and material to any matter at issue.

(2) A party that wishes the issuance of a subpoena must, at least 10 days before the date fixed for the hearing, file with the hearing officer a written request that identifies the witnesses or documents to be produced and describes the address or location in sufficient detail to permit the witnesses or documents to be found.

(3) The request for a subpoena must state the pertinent facts that the party expects to establish by the witnesses or documents and whether those facts could be established by other evidence without the use of a subpoena.

(4) The hearing officer issues the subpoenas at his or her discretion, and CMS assumes the cost of the issuance

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and the fees and mileage of any subpoenaed witness, in accordance with section 205(d) of the Act (42 U.S.C. 405(d)).

(g) *Witnesses.* Witnesses at the hearing testify under oath or affirmation, unless excused by the hearing officer for cause. The hearing officer may examine the witnesses and shall allow the parties to examine and cross-examine witnesses.

(h) *Record of hearing.* A complete record of the proceedings at the hearing is made and transcribed in all cases. It is made available to the parties upon request. The record is not closed until a decision has been issued.

(i) *Sources of hearing officer's authority.* In the conduct of the hearing, the hearing officer complies with all the provisions of title XVIII of the Act and implementing regulations, as well as with CMS Rulings issued under § 401.108 of this chapter. The hearing officer gives great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

§ 411.122 Hearing officer's decision.

(a) *Timing.* (1) If the decision is based on a review of the record, the hearing officer mails the decision to all known parties within 120 days from the date of receipt of the request for hearing.

(2) If the decision is based on an oral hearing, the hearing officer mails the decision to all known parties within 120 days from the conclusion of the hearing.

(b) *Basis, content, and distribution of hearing decision.* (1) The written decision is based on substantial evidence and contains findings of fact, a statement of reasons, and conclusions of law.

(2) The hearing officer mails a copy of the decision to each of the parties, by certified mail, return receipt requested, and includes a notice that the administrator may review the hearing decision at the request of a party or on his or her own motion.

(c) *Effect of hearing decision.* The hearing officer's decision is the final Departmental decision and is binding upon all parties unless the Administrator chooses to review that decision in accordance with § 411.124 or it is re-

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opened by the hearing officer in accordance with § 411.126.

§ 411.124 Administrator's review of hearing decision.

(a) *Request for review.* A party's request for review of a hearing officer's decision must be in writing (not in facsimile or other electronic medium) and must be received by the Administrator within 25 days from the date on the decision.

(b) *Office of the Attorney Advisor responsibility.* The Office of the Attorney Advisor examines the hearing officer's decision, the requests made by any of the parties or CMS, and any submission made in accordance with the provisions of this section in order to assist the Administrator in deciding whether to review the decision.

(c) *Administrator's discretion.* The Administrator may—

(1) Review or decline to review the hearing officer's decision;

(2) Exercise this discretion on his or her own motion or in response to a request from any of the parties; and

(3) Delegate review responsibility to the Deputy Administrator. (As used in this section, the term "Administrator" includes "Deputy Administrator" if review responsibility has been delegated.)

(d) *Basis for decision to review.* In deciding whether to review a hearing officer's decision, the Administrator considers—

(1) Whether the decision—

(i) Is based on a correct interpretation of law, regulation, or CMS Ruling;

(ii) Is supported by substantial evidence;

(iii) Presents a significant policy issue having a basis in law and regulations;

(iv) Requires clarification, amplification, or an alternative legal basis for the decision; and

(v) Is within the authority provided by statute, regulation, or CMS Ruling; and

(2) Whether review may lead to the issuance of a CMS Ruling or other directive needed to clarify a statute or regulation.

(e) *Notice of decision to review or not to review.* (1) The Administrator gives all

parties prompt written notice of his or her decision to review or not to review.

(2) The notice of a decision to review identifies the specific issues the Administrator will consider.

(f) *Response to notice of decision to review.* (1) Within 20 days from the date on a notice of the Administrator's decision to review a hearing officer's decision, any of the parties may file with the Administrator any or all of the following:

- (i) Proposed findings and conclusions.
- (ii) Supporting views or exceptions to the hearing officer's decision.
- (iii) Supporting reasons for the proposed findings and exceptions.
- (iv) A rebuttal to another party's request for review or to other submissions already filed with the Administrator.

(2) The submissions must be limited to the issues the Administrator has decided to review and confined to the record established by the hearing officer.

(3) All communications from the parties concerning a hearing officer's decision being reviewed by the Administrator must be in writing (not in facsimile or other electronic medium) and must include a certification that copies have been sent to all other parties.

(4) The Administrator does not consider any communication that does not meet the requirements of this paragraph.

(g) *Administrator's review decision.* (1) The Administrator bases his or her decision on the following:

- (i) The entire record developed by the hearing officer.
- (ii) Any materials submitted in connection with the hearing or under paragraph (f) of this section.
- (iii) Generally known facts not subject to reasonable dispute.

(2) The Administrator mails copies of the review decision to all parties within 120 days from the date of the hearing officer's decision.

(3) The Administrator's review decision may affirm, reverse, or modify the hearing decision or may remand the case to the hearing officer.

(h) *Basis and effect of remand*—(1) *Basis.* The bases for remand do not include the following:

(i) Evidence that existed at the time of the hearing and that was known or could reasonably have been expected to be known.

(ii) A court case that was either not available at the time of the hearing or was decided after the hearing.

(iii) Change of the parties' representation.

(iv) An alternative legal basis for an issue in dispute.

(2) *Effect of remand.* (i) The Administrator may instruct the hearing officer to take further action with respect to the development of additional facts or new issues or to consider the applicability of laws or regulations other than those considered during the hearing.

(ii) The hearing officer takes the action in accordance with the Administrator's instructions in the remand notice and again issues a decision.

(iii) The Administrator may review or decline to review the hearing officer's remand decision in accordance with the procedures set forth in this section.

(i) *Finality of decision.* The Administrator's review decision, or the hearing officer's decision following remand, is the final Departmental decision and is binding on all parties unless the Administrator chooses to review the decision in accordance with this section, or the decision is reopened in accordance with §411.126.

§411.126 Reopening of determinations and decisions.

(a) A determination that a GHP or LGHP is a nonconforming GHP or the decision or revised decision of a hearing officer or of the CMS Administrator may be reopened within 12 months from the date on the notice of determination or decision or revised decision, for any reason by the entity that issued the determination or decision.

(b) The decision to reopen or not to reopen is not appealable.

§411.130 Referral to Internal Revenue Service (IRS).

(a) *CMS responsibility.* After CMS determines that a plan has been a nonconforming GHP in a particular year, it refers its determination to the IRS,

but only after the parties have exhausted all CMS appeal rights with respect to the determination.

(b) *IRS responsibility.* The IRS administers section 5000 of the IRC, which imposes a tax on employers (other than governmental entities) and employee organizations that contribute to a nonconforming GHP. The tax is equal to 25 percent of the employer's or employee organization's expenses, incurred during the calendar year in which the plan is a nonconforming GHP, for each GHP, both conforming and nonconforming, to which the employer or employee organization contributes.

Subpart F—Special Rules: Individuals Eligible or Entitled on the Basis of ESRD, Who Are Also Covered Under Group Health Plans

§ 411.160 Scope.

This subpart sets forth special rules that apply to individuals who are eligible for, or entitled to, Medicare on the basis of ESRD. (Section 406.13 of this chapter contains the rules for eligibility and entitlement based on ESRD.)

[60 FR 45367, Aug. 31, 1995]

§ 411.161 Prohibition against taking into account Medicare eligibility or entitlement or differentiating benefits.

(a) *Taking into account—(1) Basic rule.* A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during the coordination period specified in § 411.162(b) and (c). Examples of actions that constitute taking into account Medicare entitlement are listed in § 411.108(a).

(2) *Applicability.* This prohibition applies for ESRD-based Medicare eligibility to the same extent as for ESRD-based Medicare entitlement. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of paragraphs (b)(2) and (c)(2) through (c)(4) of § 411.162 if the individual meets the other requirements of § 406.13 of this chapter.

(3) *Relation to COBRA continuation coverage.* This rule does not prohibit the termination of GHP coverage under title X of COBRA when termination of that coverage is expressly permitted, upon entitlement to Medicare, under 26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); or 42 U.S.C. 300bb–2.(2)(D).¹ (Situations in which Medicare is secondary to COBRA continuation coverage are set forth in § 411.162(a)(3).)

(b) *Nondifferentiation.* (1) A GHP may not differentiate in the benefits it provides between individuals who have ESRD and others enrolled in the plan, on the basis of the existence of ESRD, or the need for renal dialysis, or in any other manner.

(2) GHP actions that constitute differentiation in plan benefits (and that may also constitute “taking into account” Medicare eligibility or entitlement) include, but are not limited to the following:

(i) Terminating coverage of individuals with ESRD, when there is no basis for such termination unrelated to ESRD (such as failure to pay plan premiums) that would result in termination for individuals who do not have ESRD.

(ii) Imposing on persons who have ESRD, but not on others enrolled in the plan, benefit limitations such as less comprehensive health plan coverage, reductions in benefits, exclusions of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit,

¹COBRA requires that certain group health plans offer continuation of plan coverage for 18 to 36 months after the occurrence of certain “qualifying events,” including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of group health plan coverage unless the individual is given the opportunity to elect, and does so elect, to continue plan coverage at his or her own expense. With one exception, the COBRA amendments expressly permit termination of continuation coverage upon entitlement to Medicare. The exception is that the plan may not terminate continuation coverage of an individual (and his or her qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11 bankruptcy (26 U.S.C. 4980B(g)(1)(D) and 29 U.S.C. 1167.(3)(C)).