

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under paragraphs (a) or (b) of this section is reduced or eliminated.

[63 FR 25379, May 7, 1998]

#### § 422.390 Guarantees.

(a) *General policy.* A PSO, or the legal entity of which the PSO is a component, may apply to CMS to use the financial resources of a guarantor for the purpose of meeting the requirements in § 422.384. CMS has the discretion to approve or deny approval of the use of a guarantor.

(b) *Request to use a guarantor.* To apply to use the financial resources of a guarantor, a PSO must submit to CMS—

(1) Documentation that the guarantor meets the requirements for a guarantor under paragraph (c) of this section; and

(2) The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, profit and loss statements, and cash flow statements.

(c) *Requirements for guarantor.* To serve as a guarantor, an organization must meet the following requirements:

(1) Be a legal entity authorized to conduct business within a State of the United States.

(2) Not be under Federal or State bankruptcy or rehabilitation proceedings.

(3) Have a net worth (not including other guarantees, intangibles and restricted reserves) equal to three times the amount of the PSO guarantee.

(4) If the guarantor is regulated by a State insurance commissioner, or other State official with authority for risk-bearing entities, it must meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

(5) If the guarantor is not regulated by a State insurance commissioner, or other similar State official it must

meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties (subsidiaries and affiliates) excluded from its assets.

(d) *Guarantee document.* If the guarantee request is approved, a PSO must submit to CMS a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must—

(1) State the financial obligation covered by the guarantee;

(2) Agree to—

(i) Unconditionally fulfill the financial obligation covered by the guarantee; and

(ii) Not subordinate the guarantee to any other claim on the resources of the guarantor;

(3) Declare that the guarantor must act on a timely basis, in any case not more than 5 business days, to satisfy the financial obligation covered by the guarantee; and

(4) Meet other conditions as CMS may establish from time to time.

(e) *Reporting requirement.* A PSO must submit to CMS the current internal financial statements and annual audited financial statements of the guarantor according to the schedule, manner, and form that CMS requests.

(f) *Modification, substitution, and termination of a guarantee.* A PSO cannot modify, substitute or terminate a guarantee unless the PSO—

(1) Requests CMS's approval at least 90 days before the proposed effective date of the modification, substitution, or termination;

(2) Demonstrates to CMS's satisfaction that the modification, substitution, or termination will not result in insolvency of the PSO; and

(3) Demonstrates how the PSO will meet the requirements of this section.

(g) *Nullification.* If at any time the guarantor or the guarantee ceases to meet the requirements of this section, CMS will notify the PSO that it ceases to recognize the guarantee document. In the event of this nullification, a PSO must—

(1) Meet the applicable requirements of this section within 15 business days; and

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(2) If required by CMS, meet a portion of the applicable requirements in less than the time period granted in paragraph (g)(1) of this section.

[63 FR 25379, May 7, 1998]

### Subpart I—Organization Compliance With State Law and Preemption by Federal Law

SOURCE: 63 FR 35099, June 26, 1998, unless otherwise noted.

#### § 422.400 State licensure requirement.

Except in the case of a PSO granted a waiver under subpart H of this part, each MA organization must—

(a) Be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (as defined in §422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more MA plans;

(b) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an MA organization; and

(c) Demonstrate to CMS that—

(1) The scope of its license or authority allows the organization to offer the type of MA plan or plans that it intends to offer in the State; and

(2) If applicable, it has obtained the State certification required under paragraph (b) of this section.

#### § 422.402 Federal preemption of State law.

The standards established under this part supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to the MA plans that are offered by MA organizations.

[70 FR 4733, Jan. 28, 2005]

#### § 422.404 State premium taxes prohibited.

(a) *Basic rule.* No premium tax, fee, or other similar assessment may be imposed by any State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, or any of their political subdivisions or other govern-

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mental authorities with respect to any payment CMS makes on behalf of MA enrollees under subpart G of this part, or with respect to any payment made to MA plans by beneficiaries, or payment to MA plans by a third party on a beneficiary's behalf.

(b) *Construction.* Nothing in this section shall be construed to exempt any MA organization from taxes, fees, or other monetary assessments related to the net income or profit that accrues to, or is realized by, the organization from business conducted under this part, if that tax, fee, or payment is applicable to a broad range of business activity.

[63 FR 35099, June 26, 1998, as amended at 70 FR 4733, Jan. 28, 2005]

### Subpart J—Special Rules for MA Regional Plans

SOURCE: 70 FR 4733, Jan. 28, 2005, unless otherwise noted.

#### § 422.451 Moratorium on new local preferred provider organization plans.

CMS will not approve the offering of a local preferred provider organization plan during 2006 or 2007 in a service area unless the MA organization seeking to offer the plan was offering a local preferred provider organization plan in the service area before December 31, 2005.

#### § 422.455 Special rules for MA Regional Plans.

(a) *Coverage of entire MA region.* The service area for an MA regional plan will consist of an entire MA region established under paragraph (b) of this section, and an MA region may not be segmented as described in §422.262(c)(2).

(b) *Establishment of MA regions—*(1) *MA region.* The term “MA region” means a region within the 50 States and the District of Columbia as established by CMS under this section.

(2) *Establishment—*(i) *Initial establishment.* By January 1, 2005, CMS will establish and publish the MA regions.

(ii) *Periodic review and revision of service areas.* CMS may periodically review MA regions and may revise the regions if it determines the revision to be appropriate.

(3) *Requirements for MA regions.* CMS will establish, and may revise, MA regions in a manner consistent with the following:

(i) *Number of regions.* There will be no fewer than 10 regions, and no more than 50 regions.

(ii) *Maximizing availability of plans.* The main purpose of the regions is to maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, or geographic location, especially those residing in rural areas.

(4) *Market survey and analysis.* Before establishing MA regions, CMS will conduct a market survey and analysis, including an examination of current insurance markets, to assist CMS in determining how the regions should be established.

(c) *National plan.* An MA regional plan can be offered in more than one MA region (including all regions).

**§ 422.458 Risk sharing with regional MA organizations for 2006 and 2007.**

(a) *Terminology.* For purposes of this section—

*Allowable costs* means, with respect to an MA regional plan offered by an organization for a year, the total amount of costs that the organization incurred in providing benefits covered under the original Medicare fee-for-service program option for all enrollees under the plan in the region in the year and in providing rebatable integrated benefits, as defined in this paragraph, reduced by the portion of those costs attributable to administrative expenses incurred in providing these benefits.

*Rebatable integrated benefits* means those non-drug supplemental benefits that are funded through beneficiary rebates (described at § 422.266(b)(1)) and that CMS determines are additional health benefits not covered under the original Medicare program option and that require expenditures by the plan. For purposes of the calculation of risk corridors, these are the only supplemental benefits that count toward allowable costs.

*Target amount* means, with respect to an MA regional plan offered by an organization in a year, the total amount of payments made to the organization for enrollees in the plan for the year

(which includes payments attributable to benefits under the original Medicare fee-for-service program option as defined in § 422.100(c)(1), the total of the MA monthly basic beneficiary premium collectible for those enrollees for the year, and the total amount of rebatable integrated benefits), reduced by the amount of administrative expenses assumed in the portion of the bid attributable to benefits under original Medicare fee-for-service program option or to rebatable integrated benefits.

(b) *Application of risk corridors for benefits covered under original fee-for-service Medicare—*(1) *General rule.* This section will only apply to MA regional plans offered during 2006 or 2007.

(2) *Notification of allowable costs under the plan.* In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization must notify CMS, before that date in the succeeding year as CMS specifies, of—

(i) Its total amount of costs that the organization incurred in providing benefits covered under the original Medicare fee-for-service program option for all enrollees under the plan (as described in paragraph (a) of this section).

(ii) Its total amount of costs that the organization incurred in providing rebatable integrated benefits for all enrollees under the plan (as described in paragraph (a) of this section), and, with respect to those benefits, the portion of those costs that is attributable to administrative expenses that is in addition to the administrative expense incurred in provision of benefits under the original Medicare fee-for-service program option.

(c) *Adjustment of payment—*(1) *No adjustment if allowable costs within 3 percent of target amount.* If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there will be no payment adjustment under this section for the plan and year.

(2) *Increase in payment if allowable costs above 103 percent of target amount—*(i) *Costs between 103 and 108 percent of target amount.* If the allowable costs for the plan for the year are greater than

103 percent, but not greater than 108 percent, of the target amount for the plan and year, CMS will increase the total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount equal to 50 percent of the difference between those allowable costs and 103 percent of that target amount.

(ii) *Costs above 108 percent of target amount.* If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, CMS will increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) of the Act by an amount equal to the sum of—

(A) 2.5 percent of that target amount; and

(B) 80 percent of the difference between those allowable costs and 108 percent of that target amount.

(3) *Reduction in payment if allowable costs below 97 percent of target amount—*

(i) *Costs between 92 and 97 percent of target amount.* If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, CMS will reduce the total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and those allowable costs.

(ii) *Costs below 92 percent of target amount.* If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, CMS will reduce the total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(A) 2.5 percent of that target amount; and

(B) 80 percent of the difference between 92 percent of that target amount and those allowable costs.

(d) *Disclosure of information—(1) General rule.* Each MA organization offer-

ing an MA regional plan must provide CMS with information as CMS determines is necessary to implement this section; and

(2) According to § 422.504(d)(1)(iii), CMS has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to CMS under paragraph (b)(2) of this section.

(3) *Restriction on use of information.* Information disclosed or obtained for the purposes of this section may be used by officers, employees, and contractors of DHHS only for the purposes of, and to the extent necessary in, implementing this section.

(e) *Organizational and financial requirements—(1) General rule.* Regional MA plans offered by MA organizations must be licensed under State law, or otherwise authorized under State law, as a risk-bearing entity (as defined in § 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more plans. However, as provided for under this section, MA organizations offering MA regional plans may obtain a temporary waiver of State licensure. In the case of an MA organization that is offering an MA regional plan in an MA region, and is not licensed in each State in which it offers such an MA regional plan, the following rules apply:

(i) The MA organization must be licensed to bear risk in at least one State of the region.

(ii) For the other States in a region in which the organization is not licensed to bear risk, if it demonstrates to CMS that it has filed the necessary application to meet those requirements, CMS may temporarily waive the licensing requirement with respect to each State for a period of time as CMS determines appropriate for the timely processing of the application by the State or States.

(iii) If the State licensing application or applications are denied, CMS may extend the licensing waiver through the end of the plan year or as CMS determines appropriate to provide for a transition.

(2) *Selection of appropriate State.* In the case of an MA organization to which CMS grants a waiver and that is