

(A) A beneficiary makes any plan change (regardless of the parent organization) within the first three months of enrollment (known as rapid disenrollment), except as provided in paragraph (d)(5)(iii) of this section.

(B) Any other time period a beneficiary is not enrolled in a plan, but the plan paid compensation based on that time period.

(iii) Rapid disenrollment compensation recovery does not apply when:

(A) A beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

(B) A beneficiary's enrollment change is not in the best interests of the Medicare program, including for the following reasons:

(1) Other creditable coverage (for example, an employer plan).

(2) Moving into or out of an institution.

(3) Gain or loss of employer/union sponsored coverage.

(4) Plan termination, non-renewal, or CMS imposed sanction.

(5) To coordinate with Part D enrollment periods or the State Pharmaceutical Assistance Program.

(6) Becoming LIS or dually eligible for Medicare and Medicaid.

(7) Qualifying for another plan based on special needs.

(8) Due to an auto, facilitated, or passive enrollment.

(9) Death.

(10) Moving out of the service area.

(11) Non-payment of premium.

(12) Loss of entitlement or retroactive notice of entitlement.

(13) Moving into a 5-star plan.

(14) Moving from an LPI plan into a plan with three or more stars.

(iv)(A) When rapid disenrollment compensation recovery applies, the entire compensation must be recovered.

(B) For other compensation recovery, plans must recover a pro-rated amount of compensation (whether paid for an initial enrollment year or renewal year) from an agent or broker equal to the number of months not enrolled.

(1) If a plan has paid full initial compensation, and the enrollee disenrolls prior to the end of the enrollment year, the total number of months not en-

rolled (including months prior to the effective date of enrollment) must be recovered from the agent or broker.

(2) Example: A beneficiary enrolls upon turning 65 effective April 1 and disenrolls September 30 of the same year. The plan paid full initial enrollment year compensation. Recovery is equal to 6/12ths of the initial enrollment year compensation (for January through March and October through December).

(e) *Payments other than compensation (administrative payments).* (1) For contract years through contract year 2024, payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace.

(2) Beginning with contract year 2025, administrative payments are included in the calculation of enrollment-based compensation.

(f) *Payments for referrals.* Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed \$100 for a referral into an MA or MA-PD plan and \$25 for a referral into a PDP plan.

(g) *TPMO oversight.* In addition to any applicable FDR requirements under § 422.504(i), when doing business with a TPMP, either directly or indirectly through a downstream entity, MA plans must implement the following as a part of their oversight of TPMOs:

(1) When a TPMP is not otherwise an FDR, the MA organization is responsible for ensuring that the TPMP adheres to any requirements that apply to the MA plan.

(2) Contracts, written arrangements, and agreements between the TPMP and an MA plan, or between the TPMP and an MA plan's FDR, must ensure the TPMP:

(i) Discloses to the MA organization any subcontracted relationships used for marketing, lead generation, and enrollment.

(ii) Record all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety.

(iii) Reports to plans monthly any staff disciplinary actions or violations of any requirements that apply to the MA plan associated with beneficiary interaction to the plan.

(iv) Uses the TPMO disclaimer as required under § 422.2267(e)(41).

(3) Ensure that the TPMO, when conducting lead generating activities, either directly or indirectly for an MA organization, must, when applicable:

(i) Disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:

(A) Verbally when communicating with a beneficiary through telephone.

(B) In writing when communicating with a beneficiary through mail or other paper.

(C) Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.

(ii) Disclose to the beneficiary that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.

(4) Beginning October 1, 2024, personal beneficiary data collected by a TPMO for marketing or enrolling them into an MA plan may only be shared with another TPMO when prior express written consent is given by the beneficiary. Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

[86 FR 6112, Jan. 19, 2021, as amended at 87 FR 27899, May 9, 2022; 88 FR 22337, Apr. 12, 2023; 89 FR 30829, Apr. 23, 2024; 89 FR 63827, Aug. 6, 2024]

#### **§ 422.2276 Employer group retiree marketing.**

MA organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits

through the MA organization, and furnish these materials only to the group members. These materials are not subject to CMS prior review and approval.

### **Subpart W [Reserved]**

### **Subpart X—Requirements for a Minimum Medical Loss Ratio**

SOURCE: 78 FR 31307, May 23, 2013, unless otherwise noted.

#### **§ 422.2400 Basis and scope.**

This subpart is based on sections 1857(e)(4), 1860D–12(b)(3)(D), and 1106 of the Act, and sets forth medical loss ratio requirements for Medicare Advantage organizations, financial penalties and sanctions against MA organizations when minimum medical loss ratios are not achieved by MA organizations, and release of medical loss ratio data to entities outside of CMS.

[81 FR 80557, Nov. 15, 2016]

#### **§ 422.2401 Definitions.**

*Non-claims costs* means those expenses for administrative services that are not—

(1) Incurred claims (as provided in § 422.2420(b)(2) through (4));

(2) Expenditures on quality improving activities (as provided in § 422.2430);

(3) Licensing and regulatory fees (as provided in § 422.2420(c)(2)(i));

(4) State and Federal taxes and assessments (as provided in § 422.2420(c)(2)(ii) and (iii)).

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013]

#### **§ 422.2410 General requirements.**

(a) For contracts beginning in 2014 or later, an MA organization (defined at § 422.2) is required to report the information required under § 422.2460 for each contract under this part for each contract year.

(b) *MLR requirement.* If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following: