

(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:

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(1) The total revenue of the MA contract for the contract year.

(2) The difference between 0.85 and the MLR for the contract year.

(c) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

(d) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract per § 422.510(b)(1) and (d) effective as of the second succeeding contract year.

[78 FR 31307, May 23, 2013, as amended at 83 FR 16736, Apr. 16, 2018]

§ 422.2420 Calculation of the medical loss ratio.

(a) *Determination of MLR.* (1) The MLR for each contract under this part is the ratio of the numerator (as defined in paragraph (b) of this section) to the denominator (as defined in paragraph (c) of this section). An MLR may be increased by a credibility adjustment according to the rules at § 422.2440, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.

(2) The MLR for an MA contract—

(i) Not offering Medicare prescription drug benefits must only reflect costs and revenues related to the benefits defined at § 422.100(c); and

(ii) That includes MA–PD plans (defined at § 422.2) must also reflect costs and revenues for benefits described at § 423.104(d) through (f) of this chapter.

(b) *Determining the MLR numerator.*

(1) For a contract year, the numerator of the MLR for an MA contract (other than an MSA contract) must equal the sum of paragraphs (b)(1)(i) through (iii) of this section, and the numerator of the MLR for an MSA contract must equal the sum of paragraphs (b)(1)(i), (iii), and (iv) of this section. The numerator must be determined in accordance with paragraphs (b)(5) and (6) of this section.

(i) Incurred claims for all enrollees, as defined in paragraphs (b)(2) through (4) of this section.

(ii) The amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year.

(iii) The expenditures under the contract for activities that improve health care quality, as defined in § 422.2430.

(iv) The amount of the annual deposit into the medical savings account described at § 422.4(a)(2).

(2) *Incurred claims for clinical services and prescription drug costs.* Incurred claims must include the following:

(i) Amounts that the MA organization pays (including under capitation contracts) for covered services, described at paragraph (a)(2) of this section, provided to all enrollees under the contract.

(ii) For an MA contract that includes MA–PD plans (described in paragraph (a)(2) of this section), drug costs provided to all enrollees under the contract, as defined at § 423.2420(b)(2)(i) of this chapter.

(iii) Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.

(iv) Percentage withholds from payments made to contracted providers.

(v) Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(vi) Changes in other claims-related reserves.

(vii) Claims that are recoverable for anticipated coordination of benefits.

(viii) Claims payments recoveries received as a result of subrogation.

(ix) [Reserved]

(x) Reserves for contingent benefits and the medical claim portion of lawsuits.

(xi) The amount of incentive and bonus payments made to providers.

(3) Adjustments that must be deducted from incurred claims include the following:

(i) Overpayment recoveries received from providers.

(4) *Exclusions from incurred claims.* The following amounts must not be included in incurred claims:

(i) Non-claims costs, as defined in § 422.2401, which include the following:

(A) Amounts paid to third party vendors for secondary network savings.

(B) Amounts paid to third party vendors for any of the following:

(1) Network development.

(2) Administrative fees.

(3) Claims processing.

(4) Utilization management.

(C) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:

(1) Medical record copying costs.

(2) Attorneys' fees.

(3) Subrogation vendor fees.

(4) Bona fide service fees.

(5) Compensation to any of the following:

(i) Paraprofessionals.

(ii) Janitors.

(iii) Quality assurance analysts.

(iv) Administrative supervisors.

(v) Secretaries to medical personnel.

(vi) Medical record clerks.

(ii) Amounts paid to CMS as a remittance under § 422.2410(b).

(5) Incurred claims under this part for policies issued by one MA organization and later assumed by another entity must be reported by the assuming organizations for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding MA organization.

(6) Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(c) *Determining the MLR denominator.* For a contract year, the denominator of the MLR for an MA contract must equal the total revenue under the contract. Total revenue under the contract is as described in paragraph (c)(1) of this section, net of deductions described in paragraph (c)(2) of this section,

taking into account the exclusions described in paragraph (c)(3) of this section, and in accordance with paragraphs (c)(4) and (c)(5) of this section.

(1) CMS' payments to the MA organization for all enrollees under a contract, reported on a direct basis, including the following:

(i) Payments under § 422.304(a)(1) through (3) and (c).

(ii) The amount applied to reduce the Part B premium, as provided under § 422.266(b)(3).

(iii) Payments under § 422.304(b)(1), as reconciled per § 423.329(c)(2)(ii) of this chapter.

(iv) All premiums paid by or on behalf of enrollees to the MA organization as a condition of receiving coverage under an MA plan, including CMS' payments for low income premium subsidies under § 422.304(b)(2).

(v) All unpaid premium amounts that an MA organization could have collected from enrollees in the MA plan(s) under the contract.

(vi) All changes in unearned premium reserves.

(vii) Payments under § 423.315(e) of this chapter.

(2) The following amounts must be deducted from total revenue in calculating the MLR:

(i) *Licensing and regulatory fees.* (A) Statutory assessments to defray the operating expenses of any State or Federal department, such as the "user fee" described in section 1857(e)(2) of the Act.

(B) Examination fees in lieu of premium taxes as specified by State law.

(ii) *Federal taxes and assessments.* All Federal taxes and assessments allocated to health insurance coverage.

(iii) *State taxes and assessments.* State taxes and assessments such as the following:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.

(B) Guaranty fund assessments.

(C) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.