

§ 422.109

42 CFR Ch. IV (10–1–05 Edition)

not the primary payer. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

§ 422.109 Effect of national coverage determinations (NCDs) and legislative changes in benefits.

(a) *Definitions.* The term *significant cost*, as it relates to a particular NCD or legislative change in benefits, means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is \$100,000; and

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.308(a).

(2) The estimated cost of Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national average per capita costs.

(b) *General rule.* If CMS determines and announces that an individual NCD or legislative change in benefits meets the criteria for significant cost described in paragraph (a) of this section, a MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. If CMS determines that an NCD or legislative change in benefits does not meet the “significant cost” threshold described in § 422.109(a), the MA organization is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

(c) *Before payment adjustments become effective.* Before the contract year that payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits

become effective, the service or benefit is not included in the MA organization's contract with CMS, and is not a covered benefit under the contract. The following rules apply to these services or benefits:

(1) Medicare payment for the service or benefit is made directly by the fiscal intermediary and carrier to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.

(2) Costs for NCD services or legislative changes in benefits for which CMS intermediaries and carriers will not make payment and are the responsibility of the MA organization are—

(i) Services necessary to diagnose a condition covered by the NCD or legislative changes in benefits;

(ii) Most services furnished as follow-up care to the NCD service or legislative change in benefits;

(iii) Any service that is already a Medicare-covered service and included in the annual MA capitation rate or previously adjusted payments; and

(iv) Any services, including the costs of the NCD service or legislative change in benefits, to the extent the MA organization is already obligated to cover it as a supplemental benefit under § 422.102.

(3) Costs for significant cost NCD services or legislative changes in benefits for which CMS fiscal intermediaries and carriers will make payment are those Medicare costs not listed in paragraphs (c)(2)(i) through (c)(2)(iv) of this section.

(4) Beneficiaries are liable for any applicable coinsurance amounts.

(d) *After payment adjustments become effective.* For the contract year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect, the service or benefit is included in the MA organization's contract with CMS, and is a covered benefit under the contract. Subject to all applicable rules under this part, the MA organization must furnish, arrange, or pay for the NCD service or legislative change in benefits. MA organizations may establish separate plan rules for these services and

benefits, subject to CMS review and approval. CMS may, at its discretion, issue overriding instructions limiting or revising the MA plan rules, depending on the specific NCD or legislative change in benefits. For these services or benefits, the Medicare enrollee will be responsible for MA plan cost sharing, as approved by CMS or unless otherwise instructed by CMS.

[68 FR 50856, Aug. 22, 2003, as amended at 70 FR 4721, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

§ 422.110 Discrimination against beneficiaries prohibited.

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

- (1) Medical condition, including mental as well as physical illness.
- (2) Claims experience.
- (3) Receipt of health care.
- (4) Medical history.
- (5) Genetic information.
- (6) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (7) Disability.

(b) *Exception.* An MA organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular MA organization may not be disenrolled for that reason. An individual who is an enrollee of a particular MA organization, and who resides in the MA plan service area at the time he or she first becomes MA eligible, or, an individual enrolled by an MA organization that allows those who reside outside its MA service area to enroll in an MA plan as set forth at § 422.50(a)(3)(ii), then that individual is considered to be “enrolled” in the MA

organization for purposes of the preceding sentence.

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

§ 422.111 Disclosure requirements.

(a) *Detailed description.* An MA organization must disclose the information specified in paragraph (b) of this section—

- (1) To each enrollee electing an MA plan it offers;
- (2) In clear, accurate, and standardized form; and
- (3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The MA plan’s service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under a plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and to the extent it offers Part D as an MA-PD plan, the information in § 423.128 of this chapter; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in paragraph (f)(1) of this section;

(ii) For an MA MSA plan, the benefits under other types of MA plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the MA organization owns, controls, or has a financial interest in.

(3) *Access.* (i) The number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services; any out-of-network coverage; any point-of-service option, including the supplemental premium for that option; and how the MA organization meets the requirements of § 422.112 and § 422.114 for access to services offered under the plan.