

§411.110

42 CFR Ch. IV (10–1–07 Edition)

(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.