§ 411.108 Taking into account entitlement to Medicare.

(a) Examples of actions that constitute “taking into account”. Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

(1) Failure to pay primary benefits as required by subparts F, G, and H of this part 411.

(2) Offering coverage that is secondary to Medicare to individuals entitled to Medicare.

(3) Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162(2)(D); and 42 U.S.C. 300bb–2(2)(D)).

(4) In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability.

(5) Imposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.

(6) Charging a Medicare entitled individual higher premiums.

(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.
§ 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.

§ 411.112 Documentation of conformance.

(a) Acceptable documentation. CMS may require a GHP or LGHP to demonstrate that it has complied with the Medicare secondary payer provisions and to submit supporting documentation by an official authorized to act on behalf of the entity, under penalty of perjury. The following are examples of documentation that may be acceptable:

1. A copy of the employer’s plan or policy that specifies the services covered, conditions of coverage, benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability as compared to the provisions applicable to other enrollees and potential enrollees.

2. An explanation of the plan’s allegation that it does not owe CMS any amount CMS claims the plan owes as