

and (b)) are treated as a single employer.

(b) All employees of the members of an affiliated service group (as defined in section 414(m) of the IRC (26 U.S.C. 414m)) are treated as employed by a single employer.

(c) Leased employees (as defined in section 414(n)(2) of the IRC (26 U.S.C. 414(n)(2))) are treated as employees of the person for whom they perform services to the same extent as they are treated under section 414(n) of the IRC.

(d) In applying the IRC provisions identified in this section, HCFA relies upon regulations and decisions of the Secretary of the Treasury respecting those provisions.

§ 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.

(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.

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§411.110 Basis for determination of nonconformance.

(a) A "determination of nonconformance" is a HCFA determination that a GHP or LGHP is a nonconforming plan as provided in this section.

(b) HCFA 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) HCFA 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 HCFA 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 HCFA's ability to recover an erroneous primary payment.

§411.112 Documentation of conformance.

(a) *Acceptable documentation.* HCFA 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 HCFA any amount HCFA claims the plan owes as repayment for conditional or mistaken Medicare primary payments.

(b) *Lack of acceptable documentation.* If a GHP or LGHP fails to provide acceptable evidence or documentation that it has complied with the MSP prohibitions and requirements set forth in §411.110, HCFA may make a determination of nonconformance for both the year in which the services were furnished and the year in which the request for information was made.

§411.114 Determination of nonconformance.

(a) *Starting dates for determination of nonconformance.* HCFA's authority to determine nonconformance of GHPs begins on the following dates:

(1) On January 1, 1987 for MSP provisions that affect the disabled.

(2) On December 20, 1989 for MSP provisions that affect ESRD beneficiaries and the working aged.

(3) On August 10, 1993 for failure to refund mistaken Medicare primary payments.

(b) *Special rule for failure to repay.* A GHP that fails to comply with §411.110 (a)(1), (a)(2), or (a)(3) in a particular year is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments (in accordance with §411.110(a)(4)), the plan is also nonconforming for the subsequent year. For