

### Subpart K—Enrollment, Entitlement, and Disenrollment under Medicare Contract

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

#### § 417.420 Basic rules on enrollment and entitlement.

(a) *Enrollment.* Individuals who are entitled to benefits under both Part A and Part B of Medicare or only Part B may elect to receive those benefits through an HMO or CMP that has in effect a contract with HCFA under subpart L of this part.

(b) *Entitlement.* If a Medicare beneficiary enrolls with an HMO or CMP, HCFA pays the HMO or CMP on his or her behalf for the services to which he or she is entitled.

(c) *Beneficiary liability.* (1) The HMO or CMP may require payment, in the form of premiums or otherwise, from individuals for services not covered under Medicare, as well as deductible and coinsurance amounts attributable to Medicare covered services.

(2) As described in § 417.448, Medicare enrollees of risk HMOs or CMPs are liable for services that they obtain from sources other than the HMO or CMP, unless the services are—

- (i) Emergency or urgently needed; or
- (ii) Determined, on appeal under subpart Q of this part, to be services that should have been furnished by the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

#### § 417.422 Eligibility to enroll in an HMO or CMP.

Except as specified in §§ 417.423 and 417.424, an HMO or CMP must enroll, either for an indefinite period or for a specified period of at least 12 months, any individual who—

- (a) Is entitled to Medicare benefits under Parts A and B or under Part B only;
- (b) Lives within the geographic area served by the HMO or CMP;
- (c) Is not enrolled in any other HMO or CMP that has entered into a contract under subpart L of this part;
- (d) During an enrollment period of the HMO or CMP, completes and signs

the HMO's or CMP's application form and gives whatever information is required for enrollment;

(e) Agrees to abide by the HMO's or CMP's rules after they are disclosed to him or her in connection with the enrollment process;

(f) Is not denied enrollment by the HMO or CMP under a selection policy, if any, that has been approved by HCFA under § 417.424(b); and

(g) Is not denied enrollment by the HMO or CMP on the basis of any of the administrative criteria concerning denial of enrollment in § 417.424(a).

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

#### § 417.423 Special rules: ESRD and hospice patients.

(a) *ESRD patients.* (1) A Medicare beneficiary who has been medically determined to have end-stage renal disease is not eligible to enroll in an HMO or CMP.

(2) However, if a beneficiary is already enrolled in an HMO or CMP when he or she is determined to have end-stage renal disease, the HMO or CMP—

- (i) Must reenroll the beneficiary as required by § 417.434; and
- (ii) May not disenroll the beneficiary except as provided in § 417.460.

(b) *Hospice patients.* A Medicare beneficiary who elects hospice care under § 418.24 of this chapter is not eligible to enroll in an HMO or CMP as long as the hospice election remains in effect.

[60 FR 45677, Sept. 1, 1995]

#### § 417.424 Denial of enrollment.

(a) *Basis for denial.* An HMO or CMP may deny enrollment to an individual who meets the criteria of § 417.422 if acceptance would—

- (1) Cause the number of enrollees who are Medicare or Medicaid beneficiaries to exceed 50 percent of the HMO's or CMP's total enrollment;
- (2) Prevent the HMO or CMP from complying with any of the other contract qualifying conditions set forth in subpart J of this part;
- (3) Require the HMO or CMP to exceed its enrollment capacity; or
- (4) Cause the enrollment to become substantially nonrepresentative of the

general population in the HMO's or CMP's geographic area.

(b) *Selection policies.* (1) Denial under paragraph (a)(4) of this section must be in accordance with written selection policies approved by HCFA. (2) Enrollment of individuals will not be considered to make the enrollment of the HMO or CMP substantially nonrepresentative of the general population in the HMO's or CMP's geographic area unless, as a result of the enrollment, the proportion of the subgroup of enrollees to which the enrollee belongs as compared to the HMO's or CMP's total enrollment exceeds by at least ten percent the subgroup's proportion of the general population in the geographic area of the HMO or CMP. (A subgroup is a class of Medicare enrollees of an HMO or CMP that HCFA constructs on the basis of actuarial factors.)

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

**§ 417.426 Open enrollment requirements.**

(a) *Basic requirements.* (1) HMOs or CMPs must provide open enrollment for Medicare beneficiaries for at least 30 consecutive days during each contract year.

(2) During open enrollment, the HMO or CMP must enroll eligible Medicare beneficiaries in the order in which their applications are received and until its enrollment capacity is reached.

(3) The HMO or CMP may accept applications from Medicare beneficiaries after it has reached capacity if it places those individuals on a waiting list and enrolls them in chronological order as vacancies occur.

(4) An HMO or CMP with a risk contract must accept applications from eligible Medicare beneficiaries during the month of November 1998.

(b) *Capacity to accept new enrollees.* (1) If an HMO or CMP chooses to limit enrollments because of its capacity, it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

(2) HCFA evaluates the HMO's or CMP's submittal under paragraph (b)(1) of this section.

(3) The HMO or CMP must promptly notify HCFA if there is any change in its enrollment capacity.

(c) *Reserved vacancies.* (1) Subject to HCFA's approval, an HMO or CMP may set aside a reasonable number of vacancies for an anticipated new group contract or for anticipated new enrollees under an existing group contract that will have its enrollment period after the Medicare open enrollment period during the contract year.

(2) Any set aside vacancies that are not filled within a reasonable time after the beginning of the group contract enrollment period must be made available to Medicare beneficiaries and other nongroup applicants under the requirements of this subpart.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 63 FR 35066, June 26, 1998]

**§ 417.428 Marketing activities.**

(a) *Required marketing activities.* An HMO or CMP must meet the following requirements:

(1) Offer its plan to Medicare beneficiaries and provide to those interested in enrolling, adequate written descriptions of the HMO's or CMP's rules, procedures, benefits, fees and other charges, services, and other information necessary for beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time limited or continuous) in an appropriate manner through appropriate media, throughout its enrollment area.

(3) Submit all marketing materials to HCFA at least 45 days before their planned distribution.

(4) Include in the HMO's or CMP's written materials provided to prospective enrollees prior to enrollment, notice that the HMO or CMP is authorized by law to terminate or refuse to renew its contract with HCFA, that HCFA may also choose to terminate or refuse to renew its contact with the HMO or CMP and that termination or nonrenewal may result in termination of the individual's enrollment in the HMO or CMP.