

M+C organization in excess of costs actually incurred or expected to be incurred. Additional revenues would include such things as revenues in excess of expenses of an M+C plan, profits, contribution to surplus, risk margins, contributions to risk reserves, assessments by a related entity that do not represent a direct medical or related administrative cost, and any other premium component not reflected in direct medical care costs and administrative costs.

APR stands for the M+C plan's average per capita rates of payment. The APR is the average amount the M+C organization estimates HCFA will pay (without any needed offsets or reductions, such as, those required by § 422.250(a)(2)(ii) for M+C MSA plan enrollees) for the period covered by the ACR for all of the Medicare beneficiaries electing the M+C plan.

M+C monthly basic beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(1) for the plan, or, with respect to a M+C private fee-for-service plan, the amount filed under § 422.306(d)(1).

M+C monthly supplemental beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(2) for the M+C plan, or, with respect to an MSA or an M+C private fee-for-service plan, the amount filed under § 422.306(c)(2) or § 422.306(d)(2).

M+C monthly MSA premium means, with respect to an M+C plan, the amount of such premium filed under § 422.306(c)(1).

§ 422.304 Rules governing premiums and cost-sharing.

(a) *Monthly premiums.* The monthly premium charged to the beneficiary is—

(1) For an individual enrolled in an M+C plan (other than an M+C MSA plan) offered by an M+C organization, the sum of the M+C monthly basic beneficiary premium plus the M+C monthly supplemental beneficiary premium (if any); or

(2) For an individual enrolled in an M+C MSA plan offered by an M+C organization, the M+C monthly supplemental beneficiary premium (if any).

(b) *Uniformity.*—(1) *General rule.* The M+C monthly basic beneficiary premium, the M+C monthly supplemental beneficiary premiums, and the M+C monthly MSA premium of an M+C organization may not vary among individuals enrolled in an M+C plan (or segment of the plan as provided under paragraph (b)(2) of this section). In addition, the M+C organization may not vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any), among individuals enrolled in an M+C plan (or segment of the plan as provided under paragraph (b)(2) of this section).

(2) *Segmented service area option.* An M+C organization may apply the uniformity requirements in paragraph (b)(1) of this section to segments of an M+C plan service area (rather than to the entire service area) as long as any such segment is composed of one or more M+C payment areas, and the information specified under § 422.306 is submitted separately, as provided in that section, for each such segment.

(c) *Timing of payments.* The M+C organization must permit payments of M+C monthly basic and supplemental beneficiary premium on a monthly basis and may not terminate coverage for failure to make timely payments except as provided in § 422.74(b)(1).

(d) *Monetary inducements prohibited.* An M+C organization may not provide for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose.

[63 FR 35093, June 26, 1998, asa amended at 65 FR 40326, June 29, 2000]

§ 422.306 Submission of proposed premiums and related information.

(a) *General rule.* (1) Not later than July 1 of each year, each M+C organization and any organization intending to contract as an M+C organization in the subsequent year must submit to HCFA, in the manner and form prescribed by HCFA, for each M+C plan (or service area segment, under § 422.304(b)(2)) it intends to offer in the following year—

(i) The information specified in paragraph (b), (c), or paragraph (d) of this section for the type of M+C plan involved; and

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(ii) The service area and enrollment capacity (if any).

(2) If the submission is not complete, timely, or accurate, HCFA has the authority to impose sanctions under subpart O of this part or may choose not to renew the contract.

(b) *Information required for coordinated care plans*—(1) *Basic benefits.* For basic benefits, the following information is required:

(i) The ACR as specified in § 422.310.

(ii) The M+C monthly basic beneficiary premium.

(iii) A description of cost-sharing to be imposed under the plan, and its actuarial value.

(iv) A description of any additional benefits to be provided pursuant to § 422.312 and the actuarial value determined for those benefits.

(v) Amounts collected in the previous contract period for basic benefits.

(2) *Supplemental benefits.* For supplemental benefits, the following information is required:

(i) The ACR.

(ii) The M+C monthly supplemental beneficiary premium.

(iii) A description of supplemental benefits being offered, the cost sharing to be imposed, and their actuarial value.

(iv) Amounts collected in the previous contract period for supplemental benefits.

(c) *Information required for MSA plans.*

(1) The monthly MSA premium for basic benefits.

(2) The M+C monthly supplementary beneficiary premium for supplemental benefits.

(3) A description of all benefits offered under the M+C MSA plan.

(4) The amount of the deductible imposed under the plan.

(5) Amounts collected in the previous contract period for supplemental benefits.

(d) *Information required for M+C private fee-for-service plans.* (1) The information specified under paragraph (b)(1) of this section.

(2) The amount of the M+C monthly supplemental beneficiary premium.

(3) A description of all benefits offered under the plan.

(4) Amounts collected in the previous contract period for basic and supplemental benefits.

(e) *HCFA review*—(1) *Basic rule.* Except as specified in paragraph (e)(2) of this section, HCFA reviews and approves or disapproves the information submitted under this section.

(2) *Exception.* HCFA does not review or approve or disapprove the following information:

(i) Any amounts submitted with respect to M+C MSA plans.

(ii) The M+C monthly basic and supplementary beneficiary premiums for M+C private fee-for-service plans.

[63 FR 35093, June 26, 1998, as amended at 65 FR 40326, June 29, 2000]

§ 422.308 Limits on premiums and cost sharing amounts.

(a) *Rules for coordinated care plans.* (1) For basic benefits, the M+C monthly basic beneficiary premium (multiplied by 12) charged, plus the actuarial value of the cost-sharing applicable, on average, to beneficiaries enrolled under this part may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable, on average, to beneficiaries entitled to Medicare Part A and enrolled in Medicare Part B if they were not enrollees of an M+C organization as determined in the ACR under § 422.310. For those M+C plan enrollees that are enrolled in Medicare Part B only, the M+C monthly basic beneficiary premium (multiplied by 12) charged, plus the actuarial value of the deductibles, coinsurance and copayments applicable, on average, to those beneficiaries enrolled under this part may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable, on average, to beneficiaries enrolled in Medicare Part B if they were not enrollees of an M+C organization as determined in the ACR under § 422.310.

(2) For supplemental benefits, the M+C monthly supplemental beneficiary premium (multiplied by 12) charged, plus the actuarial value of its cost-sharing, may not exceed the amounts approved in the ACR for those benefits, as determined under § 422.310 on an annual basis.