

§ 422.309

the same geographic area or State or in the United States, or on the basis of other appropriate data.

[63 FR 35093, June 26, 1998; 63 FR 52614, Oct. 1, 1998]

§ 422.309 Incorrect collections of premiums and cost-sharing.

(a) *Definitions.* As used in this section—

(1) *Amounts incorrectly collected*

(i) Means amounts that:

(A) Exceed the limits imposed by § 422.308;

(B) In the case of a M+C private fee-for-service plan, exceed the M+C monthly basic beneficiary premium or the M+C monthly supplemental premium submitted under § 422.306; and

(C) In the case of a M+C MSA plan, exceed the M+C monthly supplemental premium submitted under § 422.306 and the deductible for basic benefits; and

(ii) Includes amounts collected from an enrollee who was believed not entitled to Medicare benefits but was later found to be entitled.

(2) *Other amounts due* are amounts due for services that were—

(i) Emergency, urgently needed services, or other services obtained outside the M+C plan; or

(ii) Initially denied but, upon appeal, found to be services the enrollee was entitled to have furnished by the M+C organization.

(b) *Basic commitments.* An M+C organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

(c) *Refund methods—*(1) *Lump-sum payment.* The M+C organization must use lump-sum payments for the following:

(i) Amounts incorrectly collected that were not collected as premiums.

(ii) Other amounts due.

(iii) All amounts due if the M+C organization is going out of business or terminating its M+C contract for an M+C plan(s).

(2) *Premium adjustment or lump-sum payment, or both.* If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the M+C organi-

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zation may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

(3) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort, the M+C organization must make the refund in accordance with State law.

(d) *Reduction by HCFA.* If the M+C organization does not make the refund required under this section by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, HCFA reduces the premium the M+C organization is allowed to charge an M+C plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the M+C organization would be subject to sanction under subpart O for failure to refund amounts incorrectly collected from M+C plan enrollees.

§ 422.310 Adjusted community rate (ACR) approval process.

(a) *General rule.* (1) Except with respect to M+C MSA plans, each M+C organization must compute a separate ACR for each M+C coordinated care or private fee-for-service plan offered to Medicare beneficiaries. In computing the ACR, the M+C organization calculates an initial rate (for years after 1999, using the methods described in paragraph (b), for 1999, under § 417.594(b)) that represents the “commercial premium” the M+C organization would charge its general non-Medicare eligible enrollment population for the basic benefits, and any mandatory supplemental benefits covered under the M+C plan. The M+C organization should also calculate a separate initial rate (using the same approach) for each optional supplemental benefit package it offers under an M+C plan. For years after 1999 the M+C organization then either adjusts that rate by the factors specified in paragraph (c) of this section or requests that HCFA adjust the rate in accordance with the procedures specified in paragraph (c)(6) of this section. For 1999, adjustments are made under section 417.594(c). All data submitted as part of the ACR process is subject to

audit by HCFA or any person or organization designated by HCFA.

(2) To calculate the adjusted excess described in section 422.312, the M+C organization or HCFA further reduces the rate for Medicare-covered services by the actuarial value of applicable Medicare coinsurance and deductibles.

(3) Separate ACRs must be calculated for Part A and Part B enrollees and Part B-only enrollees for each M+C plan offered, and for each optional supplemental benefit option.

(4) In calculating its initial rate, the M+C organization must identify and take into account anticipated revenue collectible from other payers for those services for which Medicare is not the primary payer as described in § 422.108.

(5) Except as provided in paragraph (a)(6) of this section, the M+C organization must have an adequate accounting system that is accrual based and uses generally-accepted accounting principles to develop its ACR.

(6) For M+C organizations that are part of a government entity that uses a cash basis of accounting, ACR cost data developed on this basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the asset, is acceptable.

(b) *Initial rate calculation for years after 1999.* (1) The M+C organization's initial rate for each M+C plan is calculated on a 12-month basis for non-Medicare enrollees, using either, at the M+C organization's election—

(i) A community rating system (as defined in section 1308(8) of the PHS Act, other than subparagraph (C)); or

(ii) A system, approved by HCFA, under which the M+C organization develops an aggregate premium for each M+C plan for all enrollees of that M+C plan that is weighted by the size of the various enrolled groups and individuals that compose the M+C organization's enrollment in that M+C plan. For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers (including individual subscribers) that enroll in the M+C plan on a premium basis.

(2) Regardless of which method the M+C organization uses to calculate its initial rate, the initial rate must be equal to the premium the M+C organization would charge its non-Medicare

enrollees on a yearly basis for services included in the M+C plan.

(3) Except as provided in paragraph (b)(4) of this section, the M+C organization must identify in its initial rate calculation for an M+C plan, the following components whose rates must be consistent with rates used by the M+C organization in calculating premiums for non-Medicare enrollees:

(i) Direct medical care.

(ii) Administration.

(iii) Additional Revenues.

(iv) Enrollee cost sharing (for example, deductibles, coinsurance, or copayments) for Medicare-covered services and for additional and supplemental benefits.

(4) An M+C organization that does not usually separate its premium components as described in paragraph (b)(3) of this section may calculate its initial rate with the methods it uses for its other enrolled groups if the M+C organization provides HCFA with the documentation necessary to support any adjustments the M+C organization makes to the initial rate in accordance with paragraph (c)(5) of this section.

(5) The initial rate calculation must not carry forward any losses experienced by the M+C organization during prior contract periods. The M+C organization must submit supporting documentation to assure HCFA that ACR values do not include past losses but only premiums for covered services, additional services, and supplemental benefits for the upcoming 12-month period.

(c) *Adjustment factors for years after 1999.* Adjustment factors are designed to adjust on a component basis the initial rate calculated under paragraph (b) of this section to reflect differences in utilization characteristics of the M+C organization's Medicare enrollees electing an M+C plan using a relative cost ratio. Adjustment factors are as follows:

(1) *Direct medical care.* The relative cost ratio for direct medical care for an M+an is determined by comparing the direct medical care costs actually incurred on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the direct medical care

costs of non-Medicare enrollees incurred over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(2) *Administration.* The relative cost ratio for Administration for an M+C plan is determined by comparing the administrative costs actually incurred on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the administrative costs of non-Medicare enrollees incurred over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(3) *Additional revenues.* The relative cost ratio for additional revenues for an M+C plan is determined by comparing the additional revenues collected on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the additional revenues of non-Medicare enrollees collected over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(4) *Additional adjustments.* Additional adjustments may be necessary if the M+C organization, with agreement of HCFA, determines that the adjustment of the initial rate by the relative cost ratios does not represent an accurate ACR value of the initial rate component. In addition, adjustments will be allowed that are designed to reduce ACR values to equal the actuarial value of the M+C plan charge structure.

(5) *Supporting documentation.* All adjustments made by the M+C organization must be accompanied by adequate supporting data. If an M+C organization does not have sufficient enrollment experience to develop this data, it may, during its initial contract period use reasonable estimates acceptable to HCFA to establish its ACR values.

(6) *Adjustment by HCFA.* If it is determined that the M+C organization does not have adequate data to adjust the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of Medicare enrollees, HCFA adjusts the initial rate. HCFA adjusts the rate on the basis of differences in the utilization characteristics of—

(i) Medicare and non-Medicare enrollees in other M+C plans; or

(ii) Medicare beneficiaries in the M+C organization's area, State, or the United States who are eligible to elect an M+C plan and other individuals in that same area, State, or the United States.

(d) *Special rules for certain organizations.* An M+C organization that does not have non-Medicare enrollees or sufficient Medicare enrollment experience to adequately calculate ACR values may calculate its ACR using estimates described in paragraphs (a)(1) and (a)(2) of this section as an additional adjustment described in paragraph (c)(4) of this section.

(1) The M+C organization may use an estimate of the ACR value for the direct medical and administrative components of a service or services offered using generally-accepted accounting principles.

(2) The M+C organization may use an estimate of the ACR value for the additional revenue component of a service or services offered based on the lesser of (if the information is available)—

(i) The average of additional revenues received through risk payments for health services contracted to be furnished to an enrolled population of other organizations;

(ii) The average of additional revenues received for health services furnished; or

(iii) A reasonable estimate of additional revenues of other M+C organizations in the general marketplace.

(e) *Adjustment by HCFA.* If HCFA finds that there is insufficient enrollment experience to determine the APR or ACR for a M+C plan at the beginning of a contract period, HCFA may—

(1) Determine the APR based on the enrollment experience of other M+C organizations;

(2) Determine ACR using data in the general commercial marketplace; or

(3) Determine either or both rates using the best available information, which may include enrollment experience of other M+C organizations and section 1876 risk contractors.

(f) *HCFA review.* (1) The M+C organization's methodology and computation of its ACR are subject to review and approval by HCFA. When the M+C organization submits the ACR computation, it must include adequate supporting data. Except as provided in § 422.306(e)(2), HCFA authorizes the M+C organization to collect premiums and other cost sharing amounts described in § 422.306 that are equal to the amounts calculated in the ACR.

(2) If the M+C organization is dissatisfied with an HCFA determination that the M+C organization's computation is not acceptable, the M+C organization may within 2 weeks after the date of receipt of notification of this determination, file a request for a hearing with HCFA. The request must state why the M+C organization believes the determination is incorrect and must be accompanied by any supporting evidence the M+C organization wishes to submit. The hearing is conducted by a hearing officer designated by HCFA under the hearing procedures described in subpart N.

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§ 422.312 Requirement for additional benefits.

(a) *Definitions.* As used in this section—

(1) *Excess amount* is the amount by which the APR exceeds the actuarial value of the Medicare covered services required under § 422.101(a), as determined on the basis of the ACR determined under § 422.310, as reduced for the actuarial value of the cost-sharing under Medicare Parts A and B. A separate excess amount must be determined for Part B-only enrollees.

(2) *Adjusted excess amount* is the excess amount minus any amount withheld and reserved for the organization in a stabilization fund, as provided in paragraph (c) of this section.

(b) *Requirement for additional benefits.* If there is an adjusted excess amount

for the plan it offers, the M+C organization must—

(1) Provide additional benefits with an actuarial value (less the actuarial value of any copayment or coinsurance associated with the benefit) which HCFA determines is at least equal to the adjusted excess amount; and

(2) Provide those benefits uniformly for all Medicare enrollees electing the plan.

(c) *Stabilization fund.* (1) An M+C organization may request for part of an excess amount to be withheld and reserved, for a specified number of contract periods, in the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Insurance Trust Fund in the proportions that HCFA determines to be appropriate.

(2) The reserved funds are to be used to stabilize and prevent undue fluctuations in the additional benefits that are required under this section and are provided during subsequent contract periods.

(3) Any amounts not provided as additional benefits during the period specified by the M+C organization for which the stabilization fund is established, reverts for the use of the trust funds.

(4) *Establishment of a stabilization fund.* An M+C organization's request to have monies withheld in a stabilization fund for a specific M+C plan must be made when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, other cost-sharing amounts, and related information in preparation for its next contract period.

(i) *Limit per contract period.* Except as provided in paragraph (c)(4)(iii) of this section, HCFA does not withhold in a stabilization fund more than 15 percent of the excess amount for a given contract period.

(ii) *Cumulative limit.* If HCFA has established a stabilization fund for an M+C plan, it does not approve a request for withholding made by that M+C organization for a subsequent contract period that would cause the total value of the stabilization fund to exceed 25 percent of the excess amount applicable to the M+C plan for that subsequent contract period.