

**§411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.**

(a) *Definition.* As used in this section, *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with §411.24.

(b) *Applicability.* This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

(c) *Basic rules*—(1) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(2) *Specific limitations.* Except as provided in paragraph (d) of this section, the provider or supplier—

(i) May not bill the liability insurer nor place a lien against the beneficiary's liability insurance settlement for Medicare covered services.

(ii) May only bill Medicare for Medicare-covered services; and

(iii) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under §413.35 of this chapter (when cost limits are applied to the services) or under §489.32 of this chapter (when services are partially covered).

(d) *Exceptions*—(1) *Nonparticipating suppliers.* The limitations of paragraph (c)(2) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or has not claimed payment for them under §424.64 of this chapter.

(2) *Prepaid health plans.* If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of §417.528 of this chapter apply.

(3) *Special rules for Oregon.* For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

(i) The limitations of paragraph (c)(2) of this section do not apply if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the hospital files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the hospital must withdraw its claim or lien and comply with the limitations imposed by paragraph (c)(2) of this section.

**Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions**

SOURCE: 60 FR 45362, Aug. 31, 1995, unless otherwise noted.

**§411.100 Basis and scope.**

(a) *Statutory basis.* (1) Section 1862(b) of the Act provides in part that Medicare is secondary payer, under specified conditions, for services covered under any of the following:

(i) Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. (Section 1862(b)(1)(A))

(ii) Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in §411.163, group health plans are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (Section 1862(b)(1)(C))

(iii) Large group health plans (that is, plans of employers that employ at least 100 employees) and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. (Section 1862(b)(1)(B))

(2) Sections 1862(b)(1)(A), (B), and (C) of the Act provide that group health plans and large group health plans may not take into account that the individuals described in paragraph (a)(1) of this section are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD.

(3) Section 1862(b)(1)(A)(i)(II) of the Act provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under 65. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

(4) Section 1862(b)(1)(C)(ii) of the Act provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute "differentiating" are listed in §411.161(b).

(b) *Scope.* This subpart sets forth general rules pertinent to—

(1) Medicare payment for services that are covered under a group health plan and are furnished to certain beneficiaries who are entitled on the basis of ESRD, age, or disability.

(2) The prohibition against taking into account Medicare entitlement based on age or disability, or Medicare eligibility or entitlement based on ESRD.

(3) The prohibition against differentiation in benefits between individuals who have ESRD and other individuals covered under the plan.

(4) The requirement to provide to those 65 or over the same benefits

under the same conditions as are provided to those under 65.

(5) The appeals procedures for group health plans that CMS determines are nonconforming plans.

**§411.101 Definitions.**

As used in this subpart and in subparts F through H of this part—

*COBRA* stands for Consolidated Omnibus Budget Reconciliation Act of 1985.

*Days* means calendar days.

*Employee* (subject to the special rules in §411.104) means an individual who—

(1) Is working for an employer; or

(2) Is not working for an employer but is receiving payments that are subject to FICA taxes, or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code.

*Employer* means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

*FICA* stands for the Federal Insurance Contributions Act, the law that imposes social security taxes on employers and employees under section 21 of the Internal Revenue Code.

*Group health plan (GHP)* means any arrangement made by one or more employers or employee organizations to provide health care directly or through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that—

(1) Is of, or contributed to by, one or more employers or employee organizations,

(2) If it involves more than one employer or employee organization, provides for common administration.

(3) Provides substantially the same benefits or the same benefit options to