

ESRD rates in effect prior to CY 2002 included the costs of beneficiaries with MSP, and we continued this approach. Two commenters are not correct in stating that the proposed M+C ESRD payment rates will significantly decrease payments to M+C organizations. In fact, the base rates were increased 3 percent under the method effective CY 2002. As we stated in the final notice, given current enrollment restrictions, we estimate that the age- and sex-adjusted average ESRD payment per beneficiary will result in a significant increase in payments to M+C organizations for their ESRD enrollees.

Accordingly, we are retaining the language we proposed which reflects the methodology we adopted through the 2001 notice process.

## 2. Permitting Premium Reductions as Additional Benefits Under Medicare+Choice Plans

Section 606 of the BIPA amended section 1854(f)(1) of the Act to permit M+C organizations to elect to reduce or eliminate standard Part B premiums for their M+C Medicare enrollees, as an additional benefit, if the M+C organization has an adjusted excess amount, as defined in § 422.312(a)(2), for that plan in a contract year, beginning in CY 2003. Under section 606 of the BIPA, M+C organizations can elect to accept lower payments from us and apply 80 percent of the reduction to reduce the standard Part B premiums of M+C beneficiaries enrolled in that plan. The amount of the reduction in payments to the M+C organizations may not exceed 125 percent of the Medicare standard Part B premium rate set by us for that year, which is the amount that would result in eliminating the average enrollee's liability for the Part B premium entirely. The reduction must be applied uniformly to all similarly situated enrollees of the M+C plan.

In addition, section 606 of the BIPA required that the list of information made available to each enrollee electing an M+C plan must also include a description of any reduction in the Part B premiums. We proposed revising § 422.2, § 422.111(f), § 422.250(a)(1), and § 422.312 to reflect these provisions in the regulations. We received one comment in support of these regulations and are finalizing them as proposed.

## 3. Payment of Additional Amounts for New Benefits Covered During a Contract Term

Section 611 of the BIPA amended sections 1852(a)(5) and 1853(c)(7) of the Act with the intent of limiting the financial impact on M+C organizations of new coverage requirements adopted

by the Congress. Before the enactment of the BIPA, section 1852(a)(5) provided that if a national coverage determination (NCD) of the Secretary which took effect after M+C payment rates were announced for a particular year, and that NCD would result in "a significant change in the costs to a Medicare+Choice organization," M+C organizations were not required to cover them under their contracts, but the services were instead paid for on a fee-for-service basis through our fiscal intermediaries or carriers, until the next annual M+C payment announcement is made following the coverage change. Under the pre-BIPA version of section 1853(c)(7) of the Act, if an NCD resulted in "significant" costs, we were required to "adjust appropriately" capitation payments to reflect the new costs.

Section 611 of BIPA extended these provisions to changes in coverage resulting from legislation, in addition to those resulting from NCDs. We proposed revisions to § 422.109 to reflect these amendments. We received several comments on our proposed revised regulations.

*Comment:* Several commenters expressed concern that people enrolled in M+C organizations may not understand that new benefits or services available as a result of a national coverage determination (NCD) or legislative change in benefits may be paid in a different manner than other covered benefits when we determine that the costs of NCDs or legislative changes in benefits are "significant." The commenters suggested that we publicize when new coverage is available, require M+C organizations to notify their members of the availability of the new benefits or services, and require M+C organizations to notify their members about the manner in which Medicare coverage and payment would take place. It was recommended that the notification should include a clear explanation of whether, and how much, the beneficiary might have to pay for the benefit or service until it is included in the M+C organization's capitation payment.

*Response:* We will continue to require M+C organizations to notify plan members when there is an NCD. If the NCD meets the "significant cost" threshold when the coverage is not included in the services, M+C organizations must cover the NCD under their contract in exchange for a monthly capitation payment. The M+C organization must notify plan members that original Medicare fee-for-service cost-sharing rules apply. M+C organizations are required to include an explanation of new NCDs in their next

regularly scheduled beneficiary communication. If the new NCD or legislative change in benefits meets the "significant cost" threshold per § 422.109(a), the written explanation to beneficiaries about the new coverage will include the fact that the service will be paid in accordance with original Medicare payment rules and will include information on financial liability enrollees will have.

*Comment:* One commenter suggested that the final rule require M+C organizations to provide a statement in their *Summary of Benefits* that new Medicare benefits will be paid under traditional Medicare. It was also suggested that an explanation of the method by which enrollees in an M+C plan can access new benefits and services be included in the model *Evidence of Coverage*.

*Response:* It would be misleading to state that any new Medicare benefits would be paid under traditional Medicare rules. Unless new benefits meet the "significant" cost threshold, the M+C organization is required to cover them under its contract in exchange for its capitation payment. As stated above, M+C organizations are already held responsible for notifying enrollees of new coverage and of any cost sharing liability related to a new service, if the new service meets the "significant cost" threshold. Therefore, we do not believe it is feasible or even necessary to include the notification with respect to specific NCDs in the standardized *Summary of Benefits* or the annual *Evidence of Coverage*, because NCDs can be effective at any time during the year. We believe our current policy of having M+C organizations inform enrollees of NCDs when they occur both protects beneficiaries and prevents confusion.

*Comment:* One commenter suggested that we explain, in our program memoranda on new benefits, the procedures for direct reimbursement by the fiscal intermediary and the carrier in cases that meet the "significant cost" threshold and therefore are not covered by the M+C organization.

*Response:* We will make every effort to provide the suggested explanation in program memoranda on new benefits, if direct reimbursement by fiscal intermediaries and carriers is required because the new coverage meets the "significant cost" threshold. However, because program memoranda about new benefits are sometimes released independent of, and prior to, a determination that the new benefits meet the "significant cost" threshold described in § 422.109(a), it is not always possible to include such an