transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

§ 1395w–21. Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(2) Types of Medicare+Choice plans that may be available

A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) Coordinated care plans (including regional plans)

(i) In general

Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1395w–25(d) of this title), and regional or local preferred provider organization plans (including MA regional plans).

(ii) Specialized MA plans for special needs individuals

Specialized MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title) may be any type of coordinated care plan.

(B) Combination of MSA plan and contributions to Medicare+Choice MSA

An MSA plan, as defined in section 1395w–28(b)(3) of this title, and a contribution into a Medicare+Choice medical savings account (MSA).

(C) Private fee-for-service plans

A Medicare+Choice private fee-for-service plan, as defined in section 1395w–28(b)(2) of this title.

(3) Medicare+Choice eligible individual

In this subchapter, the term ''Medicare+Choice eligible individual'' means an individual who is entitled to benefits under part A and enrolled under part B.

(b) Special rules

(1) Residence requirement

(A) In general

Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) Continuation of enrollment permitted

Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) Continuation of enrollment permitted where service changed

Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) Special rule for certain individuals covered under FEHBP or eligible for veterans or military health benefits

(A) FEHBP

An individual who is enrolled in a health benefit plan under chapter 89 of title 5 is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA and DOD

The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10 or under chapter 17 of title 38.

(3) Limitation on eligibility of qualified medicare beneficiaries and other medicaid beneficiaries to enroll in an MSA plan

An individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of

this title), a qualified disabled and working individual (described in section 1396d(s) of this title), an individual described in section 1396a(a)(10)(E)(iii) of this title, or otherwise entitled to medicare cost-sharing under a State plan under subchapter XIX is not eligible to enroll in an MSA plan.

(4) Coverage under MSA plans

(A) In general

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) Evaluation

The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this subchapter.

(C) Reports

The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) Process for exercising choice

(1) In general

The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) Coordination through Medicare+Choice organizations

(A) Enrollment

Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) Disenrollment

Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) Default

(A) Initial election

(i) In general

Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

(ii) Seamless continuation of coverage

The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing periods

An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(4) Deemed enrollment relating to converted reasonable cost reimbursement contracts

(A) In general

On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this subchapter through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1395mm(h)(5)(C)(iv) of this title) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, con-

tracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA eligible individuals described

(i) Without prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1395w–132 of this title.

(ii) With prescription drug coverage

An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1395mm(h) of this title in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) Applicable MA plan defined

In this paragraph, the term ''applicable MA plan'' means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA–PD plan; and

(ii) subparagraph (B)(ii), an MA–PD plan.

(D) Identification and notification of deemed individuals

Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) Providing information to promote informed choice

(1) In general

The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of notice

(A) Open season notification

At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) General information

The general information described in paragraph (3).

(ii) List of plans and comparison of plan options

A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) Additional information

Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1395b–2 of this title.

(B) Notifications required

(i) Notification to newly eligible Medicare Advantage eligible individuals

To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(ii) Notification related to certain deemed elections

The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1395mm(h)(5)(C)(iv) of this title to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such

plan to receive benefits under this subchapter through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) Form

The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) Periodic updating

The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) General information

General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) Benefits under original medicare fee-for-service program option

A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) Election procedures

Information and instructions on how to exercise election options under this section.

(C) Rights

A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1395w–22(b) of this title.

(D) Information on medigap and medicare select

A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1395ss of this title and provisions relating to medicare select policies described in section 1395ss(t) of this title.

(E) Potential for contract termination

The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) Catastrophic coverage and single deductible

In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) Information comparing plan options

Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) Benefits

The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) Premiums

(i) In general

The monthly amount of the premium charged to an individual.

(ii) Reductions

The reduction in part B premiums, if any.

(C) Service area

The service area of the plan.

(D) Quality and performance

To the extent available, plan quality and performance indicators for the benefits

under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) Supplemental benefits

Supplemental health care benefits, including any reductions in cost-sharing under section 1395w–22(a)(3) of this title and the terms and conditions (including premiums) for such benefits.

(5) Maintaining a toll-free number and Internet site

The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) Use of non-Federal entities

The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) Provision of information

A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) Coverage election periods

(1) Initial choice upon eligibility to make election if Medicare+Choice plans available to individual

If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) Open enrollment and disenrollment opportunities

Subject to paragraph (5)—

(A) Continuous open enrollment and disenrollment through 2005

At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) Continuous open enrollment and disenrollment for first 6 months during 2006

(i) In general

Subject to clause (ii), subparagraph (C)(iii),[1] and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) Annual 45-day period from 2011 through 2018 for disenrollment from MA plans to elect to receive benefits under the original Medicare fee-for-service program

Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011 and ending with 2018), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1395w–101 of this title.

(D) Continuous open enrollment for institutionalized individuals

At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) Limited continuous open enrollment of original fee-for-service enrollees in medicare advantage non-prescription drug plans

(i) In general

On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligi-

[1] See References in Text note below.

ble individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA–PD plan.

(ii) Unenrolled fee-for-service individual defined

In this subparagraph, the term ''unenrolled fee-for-service individual'' means, with respect to a date, a Medicare Advantage eligible individual who—

(I) is receiving benefits under this subchapter through enrollment in the original medicare fee-for-service program under parts A and B;

(II) is not enrolled in an MA plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) Limitation of one change during the applicable period

An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) No effect on coverage under a prescription drug plan

Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) Special period for certain deemed elections

(i) In general

At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

(ii) Limitation of one change

An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(G) Continuous open enrollment and disenrollment for first 3 months in 2016 and subsequent years

(i) In general

Subject to clause (ii) and subparagraph (D)—

(I) in the case of an MA eligible individual who is enrolled in an MA plan, at any time during the first 3 months of a year (beginning with 2019); or

(II) in the case of an individual who first becomes an MA eligible individual during a year (beginning with 2019) and enrolls in an MA plan, during the first 3 months during such year in which the individual is an MA eligible individual;

such MA eligible individual may change the election under subsection (a)(1).

(ii) Limitation of one change during open enrollment period each year

An individual may change the election pursuant to clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(iii) Limited application to part D

Clauses (i) and (ii) of this subparagraph shall only apply with respect to changes in enrollment in a prescription drug plan under part D in the case of an individual who, previous to such change in enrollment, is enrolled in a Medicare Advantage plan.

(iv) Limitations on marketing

Pursuant to subsection (j), no unsolicited marketing or marketing materials may be sent to an individual described in clause (i) during the continuous open enrollment and disenrollment period established for the individual under such clause, notwithstanding marketing guidelines established by the Centers for Medicare & Medicaid Services.

(3) Annual, coordinated election period

(A) In general

Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) Annual, coordinated election period

For purposes of this section, the term ''annual, coordinated election period'' means—

(i) with respect to a year before 2002, the month of November before such year;

(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

(C) Medicare+Choice health information fairs

During the fall season of each year (beginning with 1999) and during the period de-

scribed in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) Special information campaigns

During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1395mm of this title, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) Special election periods

Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) Special rules for MSA plans

Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) Open enrollment periods

Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) Effectiveness of elections and changes of elections

(1) During initial coverage election period

An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1395q of this title) in order to prevent retroactive coverage.

(2) During continuous open enrollment periods

An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) Annual, coordinated election period

An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B), other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) Other periods

An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) Guaranteed issue and renewal

(1) In general

Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) Priority

If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1395w–22(b) of this title, among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) Limitation on termination of election

(A) In general

Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) Basis for termination of election

A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1395w–26 of this title that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) Consequence of termination

(i) Terminations for cause

Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) Termination based on plan termination or service area reduction

Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

(D) Organization obligation with respect to election forms

Pursuant to a contract under section 1395w–27 of this title, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) Approval of marketing material and application forms

(1) Submission

No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) Review

The standards established under section 1395w–26 of this title shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) Deemed approval (1-stop shopping)

In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) Prohibition of certain marketing practices

Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1395w–26 of this title. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) Special treatment of marketing material following model marketing language

In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) Required inclusion of plan type in plan name

For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) Strengthening the ability of States to act in collaboration with the Secretary to address fraudulent or inappropriate marketing practices

(A) Appointment of agents and brokers

Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) Compliance with State information requests

Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) Effect of election of Medicare+Choice plan option

(1) Payments to organizations

Subject to sections 1395w–22(a)(5), 1395w–23(a)(4), 1395w–23(g), 1395w–23(h), 1395ww(d)(11), 1395ww(h)(3)(D), and 1395w–23(m) of this title, payments under a contract with a Medicare+Choice organization under section 1395w–23(a) of this title with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) Only organization entitled to payment

Subject to sections 1395w–23(a)(4), 1395w–23(e), 1395w–23(g), 1395w–23(h), 1395w–27(f)(2), 1395w–27a(h), 1395ww(d)(11), and 1395ww(h)(3)(D) of this title, only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this subchapter for services furnished to the individual.

(3) FFS payment for expenses for kidney acquisitions

Paragraphs (1) and (2) shall not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1395w–22(a)(1)(B)(i) of this title.

(j) Prohibited activities described and limitations on the conduct of certain other activities

(1) Prohibited activities described

The following prohibited activities are described in this paragraph:

(A) Unsolicited means of direct contact

Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) Cross-selling

The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) Meals

The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) Sales and marketing in health care settings and at educational events

Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies),

except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) Limitations

The Secretary shall establish limitations with respect to at least the following:

(A) Scope of marketing appointments

The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.

(B) Co-branding

The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) Limitation of gifts to nominal dollar value

The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) Compensation

The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) Required training, annual retraining, and testing of agents, brokers, and other third parties

The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

(Aug. 14, 1935, ch. 531, title XVIII, §1851, as added Pub. L. 105–33, title IV, §4001, Aug. 5, 1997, 111 Stat. 275; amended Pub. L. 106–113, div. B, §1000(a)(6) [title III, §321(k)(6)(A), title V, §§501(a)(1), (b), (c), 502(a), 519(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–378 to 1501A–380, 1501A–385; Pub. L. 106–554, §1(a)(6) [title VI, §§606(a)(2)(C), 613(a), 619(a), 620(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–558, 2763A–560, 2763A–563; Pub. L. 107–188, title V, §532(a), (c)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, §102(a), (c)(1), title II, §§221(a)(1), (d)(5), 222(*l*)(3)(A), (B), (D), (E), 231(a), 233(b), (d), 237(b)(2)(A), Dec. 8, 2003, 117 Stat. 2152, 2154, 2180, 2193, 2206, 2207, 2209, 2212; Pub. L. 109–432, div. B, title II, §206(a), Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, §2, July 18, 2007, 121 Stat. 244; Pub. L. 110–275, title I, §103(a)(1), (b)(1), (c)(1), (d)(1), July 15, 2008, 122 Stat. 2498–2501; Pub. L. 111–5, div. B, title IV, §4102(d)(2), Feb. 17, 2009, 123 Stat. 486; Pub. L. 111–148, title III, §§3201(e)(2)(A)(i), 3204(a)(1), (b), Mar. 23, 2010, 124 Stat. 446, 456; Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040; Pub. L. 114–10, title II, §209(b)(1)–(2)(B)(i), (3), (c), Apr. 16, 2015, 129 Stat. 147–150; Pub. L. 114–255, div. C, title XVII, §§17005, 17006(a)(1), (c)(2), Dec. 13, 2016, 130 Stat. 1333–1335.)

Editorial Notes

REFERENCES IN TEXT

Subsec. (e)(2)(C), referred to in subsec. (e)(2)(B)(i), was amended generally by section 3204(a)(1) of Pub. L. 111–148 and, as so amended, no longer contains a cl. (iii).

AMENDMENTS

2016—Subsec. (a)(3). Pub. L. 114–255, §17006(a)(1), struck out subpar. (A) designation and heading, substituted ''In this subchapter,'' for ''In this subchapter, subject to subparagraph (B),'', and struck out subpar. (B), which provided a special rule for end-stage renal disease.

Subsec. (e)(2)(C). Pub. L. 114–255, §17005(1), inserted ''from 2011 through 2018'' after ''45-day period'' in heading and ''and ending with 2018'' after ''beginning with 2011'' in text.

Subsec. (e)(2)(G). Pub. L. 114–255, §17005(2), added subpar. (G).

Subsec. (i)(3). Pub. L. 114–255, §17006(c)(2), added par. (3).

2015—Subsec. (a)(3)(B). Pub. L. 114–10, §209(b)(3), inserted concluding provisions.

Subsec. (c)(1). Pub. L. 114–10, §209(b)(1)(A), substituted ''Subject to paragraph (4), such elections'' for ''Such elections''.

Subsec. (c)(4). Pub. L. 114–10, §209(b)(1)(B), added par. (4).

Subsec. (d)(2)(B). Pub. L. 114–10, §209(c), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Pub. L. 114–10, §209(c)(1), which directed the substitution of ''Notifications required'' for ''Notification to newly eligible medicare advantage eligible individuals'' in heading, was executed by making the substitution for ''Notification to newly eligible Medicare+Choice eligible individuals'' to reflect the probable intent of Congress.

Subsec. (e)(2)(F). Pub. L. 114–10, §209(b)(2)(A), added subpar. (F).

Subsec. (e)(6)(A). Pub. L. 114–10, §209(b)(2)(B)(i), substituted ''paragraph (1), during the period described in paragraph (2)(F),'' for ''paragraph (1),''.

2010—Subsec. (b)(1)(C). Pub. L. 111–148, §3201(e)(2)(A)(i), which directed that subpar. (C) be struck out, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (e)(2)(C). Pub. L. 111–148, §3204(a)(1), amended subpar. (C) generally. Prior to amendment, subpar. (C) related to continuous open enrollment and disenrollment for first 3 months of a year after 2006.

Subsec. (e)(3)(B)(iv). Pub. L. 111–148, §3204(b)(2)(A), substituted '', 2008, 2009, and 2010'' for ''and succeeding years''.

Subsec. (e)(3)(B)(v). Pub. L. 111–148, §3204(b)(1), (2)(B), (3), added cl. (v).

2009—Subsec. (i)(1). Pub. L. 111–5 substituted ''1395ww(h)(3)(D), and 1395w–23(m)'' for ''and 1395ww(h)(3)(D)''.

2008—Subsec. (h)(4)(A). Pub. L. 110–275, §103(a)(1)(A)(i)(I)(aa), substituted '', subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates'' for ''cash or other monetary rebates''.

Subsec. (h)(4)(C). Pub. L. 110–275, §103(a)(1)(A)(i)(I)(bb)–(III), added subpar. (C).

Subsec. (h)(4)(D). Pub. L. 110–275, §103(b)(1)(A), added subpar. (D).

Subsec. (h)(6). Pub. L. 110–275, §103(c)(1), added par. (6).

Subsec. (h)(7). Pub. L. 110–275, §103(d)(1), added par. (7).

Subsec. (j). Pub. L. 110–275, §103(a)(1)(A)(ii), added subsec. (j).

Subsec. (j)(2). Pub. L. 110–275, §103(b)(1)(B), added par. (2).

2007—Subsec. (e)(2)(E)(i). Pub. L. 110–48, §2(1), substituted ''the period beginning on January 1, 2007, and ending on July 31, 2007,'' for ''2007 or 2008''.

Subsec. (e)(2)(E)(iii). Pub. L. 110–48, §2(2), substituted ''the applicable period'' for ''year'' in heading and ''the period described in such clause'' for ''the year'' in text.

2006—Subsec. (e)(2)(E). Pub. L. 109–432 added subpar. (E).

2003—Subsec. (a)(1). Pub. L. 108–173, §102(c)(1)(A), (C), inserted ''(other than qualified prescription drug benefits)'' after ''benefits'' in introductory provisions and inserted concluding provisions.

Subsec. (a)(1)(B). Pub. L. 108–173, §102(c)(1)(B), substituted comma for period at end.

Subsec. (a)(2)(A). Pub. L. 108–173, §221(a)(1), substituted ''Coordinated care plans (including regional plans)'' for ''Coordinated care plans'' in heading, inserted cl. (i) designation and heading before ''Coordinated'', and inserted ''regional or local'' before ''preferred provider organization plans'' and ''(including MA regional plans)'' before period at end.

Subsec. (a)(2)(A)(ii). Pub. L. 108–173, §231(a), added cl. (ii).

Subsec. (a)(3)(B)(ii). Pub. L. 108–173, §222(*l*)(3)(D), made technical amendment to reference in original act which appears in text as reference to subsection (e)(4)(A) of this section.

Subsec. (b)(1)(B). Pub. L. 108–173, §222(*l*)(3)(A)(i), (ii), substituted ''an MA local plan'' for ''a plan'' and ''benefits under the original medicare fee-for-service program option'' for ''basic benefits described in section 1395w–22(a)(1)(A) of this title''.

Subsec. (b)(1)(C). Pub. L. 108–173, §222(*l*)(3)(A)(iii), substituted ''in an MA local plan'' for ''in a Medicare+Choice plan'' in introductory provisions.

Subsec. (b)(4). Pub. L. 108–173, §233(b)(1), struck out ''on a demonstration basis'' after ''plans'' in heading.

Subsec. (b)(4)(A). Pub. L. 108–173, §233(b)(2), struck out first sentence which read as follows: ''An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.''

Subsec. (b)(4)(C). Pub. L. 108–173, §233(b)(3), struck out at end ''The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).''

Subsec. (d)(3)(F). Pub. L. 108–173, §222(*l*)(3)(B)(i), added subpar. (F).

Subsec. (d)(4)(A)(ii). Pub. L. 108–173, §222(*l*)(3)(B)(ii), inserted '', including information on the single deductible (if applicable) under section 1395w–27a(b)(1) of this title'' after ''cost sharing''.

Subsec. (d)(4)(B)(i). Pub. L. 108–173, §222(*l*)(3)(B)(iii), substituted ''monthly amount of the premium charged to an individual'' for ''Medicare+Choice monthly basic beneficiary premium and Medicare+Choice monthly supplemental beneficiary premium, if any, for the plan or, in the case of an MSA plan, the Medicare+Choice monthly MSA premium''.

Subsec. (d)(4)(E). Pub. L. 108–173, §222(*l*)(3)(B)(iv), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''Whether the organization offering the plan includes mandatory supplemental benefits in its base benefit package or offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.''

Subsec. (e)(1). Pub. L. 108–173, §102(a)(4), inserted at end ''If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.''

Subsec. (e)(2). Pub. L. 108–173, §102(a)(1)(A), substituted ''2005'' and ''2006'' for ''2004'' and ''2005'', respectively, wherever appearing.

Subsec. (e)(2)(B)(i). Pub. L. 108–173, §102(a)(6)(A), inserted '', subparagraph (C)(iii),'' after ''clause (ii)''.

Subsec. (e)(2)(C)(i). Pub. L. 108–173, §102(a)(6)(B), substituted ''clauses (ii) and (iii)'' for ''clause (ii)''.

Subsec. (e)(2)(C)(iii). Pub. L. 108–173, §102(a)(6)(C), added cl. (iii).

Subsec. (e)(3)(B). Pub. L. 108–173, §102(a)(2), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year.''

Subsec. (e)(3)(C). Pub. L. 108–173, §102(a)(3)(A), inserted ''and during the period described in subparagraph (B)(iii)'' after ''(beginning with 1999)''.

Subsec. (e)(3)(D). Pub. L. 108–173, §102(a)(3)(B), in heading, substituted ''campaigns'' for ''campaign in 1998'' and, in text, inserted at end ''During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.''

Subsec. (e)(4). Pub. L. 108–173, §102(a)(1)(B), substituted ''2006'' for ''2005'' in two places.

Subsec. (e)(5)(A)(i). Pub. L. 108–173, §233(d)(1), inserted ''or'' at end.

Subsec. (e)(5)(A)(ii). Pub. L. 108–173, §233(d)(2), substituted semicolon for '', or''.

Subsec. (e)(5)(A)(iii). Pub. L. 108–173, §233(d)(3), struck out cl. (iii) which read as follows: ''the month of November 1998;''.

Subsec. (f)(1). Pub. L. 108–173, §222(*l*)(3)(E), substituted ''subsection (e)(1)'' for ''subsection (e)(1)(A)''.

Subsec. (f)(3). Pub. L. 108–173, §102(a)(5), inserted '', other than the period described in clause (iii) of such subsection'' after ''subsection (e)(3)(B)''.

Subsec. (i)(1). Pub. L. 108–173, §237(b)(2)(A)(i), inserted ''1395w–23(a)(4),'' after ''Subject to sections 1395w–22(a)(5),''.

Subsec. (i)(2). Pub. L. 108–173, §237(b)(2)(A)(ii), inserted ''1395w–23(a)(4),'' after ''Subject to sections''.

Pub. L. 108–173, §221(d)(5), inserted ''1395w–27a(h),'' after ''1395w–27(f)(2),''.

2002—Subsec. (e)(2)(A). Pub. L. 107–188, §532(a)(1), substituted ''through 2004'' for ''through 2001'' in heading and ''during the period beginning January 1, 1998, and ending on December 31, 2004'' for ''during 1998, 1999, 2000, and 2001'' in text.

Subsec. (e)(2)(B). Pub. L. 107–188, §532(a)(2), substituted ''during 2005'' for ''during 2002'' in heading.

Subsec. (e)(2)(B)(i), (C)(i). Pub. L. 107–188, §532(a)(3), substituted ''2005'' for ''2002'' wherever appearing.

Subsec. (e)(2)(D). Pub. L. 107–188, §532(a)(4), substituted ''2004'' for ''2001''.

Subsec. (e)(3)(B). Pub. L. 107–188, §532(c)(1)(A), substituted ''means, with respect to a year before 2003 and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year'' for ''means, with respect to a calendar year (beginning with 2000), the month of November before such year''.

Subsec. (e)(4). Pub. L. 107–188, §532(a)(5), substituted ''2005'' for ''2002'' in introductory and concluding provisions.

Subsec. (e)(6)(A). Pub. L. 107–188, §532(c)(1)(B), substituted ''during the annual, coordinated election pe-

riod under paragraph (3) for each subsequent year'' for ''each subsequent year (as provided in paragraph (3))''.

2000—Subsec. (a)(3)(B). Pub. L. 106–554, §1(a)(6) [title VI, §620(a)], substituted ''except that—'' and cls. (i) and (ii) for ''except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan.''

Subsec. (d)(4)(B). Pub. L. 106–554, §1(a)(6) [title VI, §606(a)(2)(C)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (f)(2). Pub. L. 106–554, §1(a)(6) [title VI, §619(a)], struck out '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before period at end.

Subsec. (h)(1)(A). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(1)], inserted ''(or 10 days in the case described in paragraph (5))'' after ''45 days''.

Subsec. (h)(5). Pub. L. 106–554, §1(a)(6) [title VI, §613(a)(2)], added par. (5).

1999—Subsec. (b)(1)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(1)], inserted ''and except as provided in subparagraph (C)'' after ''may otherwise provide''.

Subsec. (b)(1)(C). Pub. L. 106–113, §1000(a)(6) [title V, §501(c)(2)], added subpar. (C).

Subsec. (e)(2)(B)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(1)], inserted ''and subparagraph (D)'' after ''clause (ii)''.

Subsec. (e)(2)(C)(i). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(2)], inserted ''and subparagraph (D)'' after ''clause (ii)''.

Subsec. (e)(2)(D). Pub. L. 106–113, §1000(a)(6) [title V, §501(b)(3)], added subpar. (D).

Subsec. (e)(3)(C). Pub. L. 106–113, §1000(a)(6) [title V, §519(a)], substituted ''During the fall season'' for ''In the month of November''.

Subsec. (e)(4)(A). Pub. L. 106–113, §1000(a)(6) [title V, §501(a)(1)], added subpar. (A) and struck out former subpar. (A) which read as follows: ''the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;''.

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title V, §502(a)], inserted ''or change'' before ''is made'' and '', except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made'' before the period at end.

Subsec. (i)(2). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(6)(A)], struck out ''and'' after ''1395w–27(f)(2),''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. C, title XVII, §17006(a)(3), Dec. 13, 2016, 130 Stat. 1334, provided that: ''The amendments made by this subsection [amending this section and sections 1395w–22 and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2021.''

Pub. L. 114–255, div. C, title XVII, §17006(c)(3), Dec. 13, 2016, 130 Stat. 1335, provided that: ''The amendments made by this subsection [amending this section and section 1395w–22 of this title] shall apply with respect to plan years beginning on or after January 1, 2021.''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, provided that sections 3201 (amending this section and sections 1395w–23, 1395w–24, 1395w–27a, 1395w–29, and 1395eee of this title and enacting provisions set out as notes under this section and section 1395w–24 of this title) and 3203 (amending section 1395w–23 of this title) of Pub. L. 111–148, and the amendments made by such sections, were repealed, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3201(e)(2)(B), Mar. 23, 2010, 124 Stat. 447, which provided that amendments by section 3201(e)(2) of Pub. L. 111–148 (amending this section and sections 1395w–23 and 1395w–24 of this title) would take effect on Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, §1102(a), Mar. 30, 2010, 124 Stat. 1040, effective as if included in the enactment of Pub. L. 111–148.

Pub. L. 111–148, title III, §3204(a)(2), Mar. 23, 2010, 124 Stat. 456, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply with respect to 2011 and succeeding years.''

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §103(a)(3), July 15, 2008, 122 Stat. 2499, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009.''

Pub. L. 110–275, title I, §103(b)(3), July 15, 2008, 122 Stat. 2500, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall take effect on a date specified by the Secretary (but in no case later than November 15, 2008).''

Pub. L. 110–275, title I, §103(d)(3), July 15, 2008, 122 Stat. 2501, provided that: ''The amendments made by this subsection [amending this section and section 1395w–104 of this title] shall apply to plan years beginning on or after January 1, 2009.''

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title I, §102(c)(2), Dec. 8, 2003, 117 Stat. 2154, provided that: ''The amendments made by this subsection [amending this section] shall apply on and after January 1, 2006.''

Pub. L. 108–173, title II, §223(a), Dec. 8, 2003, 117 Stat. 2207, provided that: ''The amendments made by this subtitle [subtitle C (§§221–223) of title II of Pub. L. 108–173, enacting section 1395w–27a of this title and amending this section and sections 1395r, 1395s, 1395w, 1395w–22 to 1395w–24, 1395w–27, and 1395w–28 of this title] shall apply with respect to plan years beginning on or after January 1, 2006.''

Pub. L. 108–173, title II, §231(f)(1), Dec. 8, 2003, 117 Stat. 2208, provided that: ''The amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title] shall take effect upon the date of the enactment of this Act [Dec. 8, 2003].''

Amendment by section 237(b)(2)(A) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(c)(2), June 12, 2002, 116 Stat. 696, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to the annual, coordinated election period for years beginning with 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, §606(a)(2)(C)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §613(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to marketing material submitted on or after January 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title VI, §619(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–563, provided that: ''The amendment made by this section [amending this section] shall apply to elections and changes of coverage made on or after June 1, 2001.''

Pub. L. 106–554, §1(a)(6) [title VI, §620(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–564, provided that:

''(1) IN GENERAL.—The amendment made by subsection (a) [amending this section] shall apply to terminations and discontinuations occurring on or after the date of the enactment of this Act [Dec. 21, 2000].

''(2) APPLICATION TO PRIOR PLAN TERMINATIONS.—Clause (ii) of section 1851(a)(3)(B) of the Social Security Act [42 U.S.C. 1395w–21(a)(3)(B)(ii)] (as inserted by subsection (a)) shall also apply to individuals whose enrollment in a Medicare+Choice plan was terminated or discontinued after December 31, 1998, and before the date of the enactment of this Act. In applying this paragraph, such an individual shall be treated, for purposes of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], as having discontinued enrollment in such a plan as of the date of the enactment of this Act.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(k)(6)(A)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 501(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–379, provided that:

''(1) The amendments made by subsection (a) [amending this section and section 1395ss of this title] apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act [Nov. 29, 1999].

''(2) The amendments made by subsection (c) [amending this section] apply to elections made on or after the date of the enactment of this Act [Nov. 29, 1999] with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 502(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that: ''The amendments made by this section [amending this section] apply to elections and changes of coverage made on or after January 1, 2000.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 519(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–385, provided that: ''The amendment made by subsection (a) [amending this section] first applies to campaigns conducted beginning in 2000.''

REGULATIONS

Pub. L. 108–173, title II, § 223(b), Dec. 8, 2003, 117 Stat. 2207, provided that: ''The Secretary [of Health and Human Services] shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] to carry out the provisions of this Act [see Tables for classification].''

CONSTRUCTION

Pub. L. 108–173, title II, § 221(b)(2), Dec. 8, 2003, 117 Stat. 2181, provided that: ''Nothing in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation.''

NO CUTS IN GUARANTEED BENEFITS

Pub. L. 111–148, title III, § 3602, Mar. 23, 2010, 124 Stat. 538, provided that: ''Nothing in this Act [see Short Title note set out under section 18001 of this title] shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.''

IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM

Pub. L. 108–173, title II, § 201, Dec. 8, 2003, 117 Stat. 2176, provided that:

''(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by this Act [see Tables for classification]).

''(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to 'Medicare+Choice' is deemed a reference to 'Medicare Advantage' and 'MA'.

''(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary [of Health and Human Services] shall provide for an appropriate transition in the use of the terms 'Medicare+Choice' and 'Medicare Advantage' (or 'MA') in reference to the program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to 'Medicare Advantage' or 'MA' shall be deemed to include a reference to 'Medicare+Choice'.''

REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS

Pub. L. 108–173, title II, § 211(g), Dec. 8, 2003, 117 Stat. 2178, directed the Secretary of Health and Human Services to submit to Congress, not later than July 1, 2006, a report that described the impact of additional financing provided under Pub. L. 108–173 and other Acts on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING

Pub. L. 108–173, title II, § 211(h), Dec. 8, 2003, 117 Stat. 2179, directed the Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under this part, to conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in subsection (a)(3) of this section, and to submit a report to Congress on such study not later than Dec. 31, 2004.

MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS

Pub. L. 108–173, title II, § 221(a)(2), Dec. 8, 2003, 117 Stat. 2180, directed the Secretary of Health and Human Services not to permit the offering of a local preferred provider organization plan under this part during 2006 or 2007 in a service area unless such plan was offered under this part (including under a demonstration project under this part) in such area as of Dec. 31, 2005.

SPECIALIZED MA PLANS

Pub. L. 110–275, title I, § 164(b), July 15, 2008, 122 Stat. 2571, provided that: ''During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals.''

Pub. L. 110–173, title I, § 108(b), Dec. 29, 2007, 121 Stat. 2496, provided that:

''(1) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Mod-

ernization Act of 2003 [Pub. L. 108–173] (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.]. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

''(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008.''

Pub. L. 108–173, title II, §231(d), Dec. 8, 2003, 117 Stat. 2208, provided that: ''In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act [42 U.S.C. 1395w–21(a)(2)(A)(ii)] (as added by subsection (a)) and section 1859(b)(6) of such Act [42 U.S.C. 1395w–28(b)(6)] (as added by subsection (b)), the Secretary [of Health and Human Services] may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals.''

Pub. L. 108–173, title II, §231(e), Dec. 8, 2003, 117 Stat. 2208, provided that: ''Not later than December 31, 2007, the Secretary [of Health and Human Services] shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c) [amending this section and section 1395w–28 of this title].''

MEDPAC STUDY ON CONSUMER COALITIONS

Pub. L. 106–554, §1(a)(6) [title I, §124], Dec. 21, 2000, 114 Stat. 2763, 2763A–478, directed the Medicare Payment Advisory Commission to conduct a study examining the use of consumer coalitions in the marketing of Medicare+Choice plans under the medicare program under this subchapter and to submit a report on the study to Congress no later than 1 year after Dec. 21, 2000.

REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §551], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, directed the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, to submit to Congress, no later than Apr. 1, 2001, a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries.

REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, directed the Medicare Payment Assessment Commission to submit to Congress, no later than 1 year after Nov. 29, 1999, a report on specific legislative changes that should be made to make MSA plans a viable option under the Medicare+Choice program.

GAO AUDIT AND REPORTS ON PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §553(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–393, provided that:

''(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.

''(3) [(2)] REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a) [enacting provisions set out as a note under section 1395ss of this title], together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to eligible medicare beneficiaries.''

ENROLLMENT TRANSITION RULE

Pub. L. 105–33, title IV, §4002(c), Aug. 5, 1997, 111 Stat. 329, provided that: ''An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act [42 U.S.C. 1395w–21 et seq.] if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).''

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 105–33, title IV, §4002(f)(2), Aug. 5, 1997, 111 Stat. 330, directed the Secretary of Health and Human Services to submit to Congress, no later than 6 months after Aug. 5, 1997, proposed technical and conforming amendments in the law as required by the provisions of chapter 1 (§§4001–4006) of subtitle A of title IV of Pub. L. 105–33.

REPORT ON INTEGRATION AND TRANSITION

Pub. L. 105–33, title IV, §4014(c), Aug. 5, 1997, 111 Stat. 337, directed the Secretary of Health and Human Services to submit to Congress, no later than Jan. 1, 1999, a plan which provided for the integration of health plans offered by social health maintenance organizations and similar plans as an option under the Medicare+Choice program under this part, for a transition for such organizations operating under demonstration project authority, and for appropriate payment levels for plans offered by such organizations.

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §4018, Aug. 5, 1997, 111 Stat. 346, provided that:

''(a) DEMONSTRATION PROJECT.—

''(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the 'project') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as added by section 4001 of this Act), in an area.

''(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

''(A) the design of the project;

''(B) the selection criteria for the third-party contractor; and

''(C) the establishment of performance standards, as described in paragraph (3).

''(3) PERFORMANCE STANDARDS.—

''(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

''(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compli-

ance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

''(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

''(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

''(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

''(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.''

§ 1395w–22. Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w–28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term ''benefits under the original medicare fee-for-service program option'' means, subject to subsection (m), those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1395w–27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).

(III) Skilled nursing care.

(IV) Clinical diagnostic laboratory test administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 and the administration of such test.

(V) Specified COVID–19 testing-related services (as described in section 1395*l*(cc)(1) of this title) for which payment would be payable under a specified outpatient payment provision described in section 1395*l*(cc)(2) of this title.

(VI) A COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title.

(VII) A drug or biological product that is a selected drug (as referred to in section 1320f–1(c) of this title).

(VIII) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv), other than subclauses (IV), (V), and (VI) of such clause, for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(vi) Prohibition of application of certain requirements for COVID–19 testing

In the case of a product or service described in subclause (IV) or (V), respectively, of clause (iv) that is administered or furnished during any portion of the emergency period described in such subclause beginning on or after March 18, 2020, an MA plan may not impose any prior authorization or other utilization management requirements with respect to the coverage of such a product or service under such plan.

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least