ices to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).''

TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS

Pub. L. 111–148, title III, § 3207, Mar. 23, 2010, 124 Stat. 459, provided that: ''For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject '2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.''

STUDY OF MULTI-YEAR CONTRACTS

Pub. L. 108–173, title I, § 107(d), Dec. 8, 2003, 117 Stat. 2171, directed the Secretary of Health and Human Services to provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under this part and part D of this subchapter on a multi-year basis, and to submit to Congress a report on such study not later than Jan. 1, 2007.

IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS

Pub. L. 105–33, title IV, § 4002(g), Aug. 5, 1997, 111 Stat. 330, provided that: ''Section 1857(e)(2) of the Social Security Act [42 U.S.C. 1395w–27(e)(2)] (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act [42 U.S.C. 1395w–21].''

§ 1395w–27a. Special rules for MA regional plans

(a) Regional service area; establishment of MA regions

(1) Coverage of entire MA region

The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1395w–24(h) of this title shall not apply to such a plan.

(2) Establishment of MA regions

(A) MA region

For purposes of this subchapter, the term ''MA region'' means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) Establishment

(i) Initial establishment

Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

(ii) Periodic review and revision of service areas

The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) Requirements for MA regions

The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

(i) Number of regions

There shall be no fewer than 10 regions, and no more than 50 regions.

(ii) Maximizing availability of plans

The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

(D) Market survey and analysis

Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) National plan

Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

(b) Application of single deductible and catastrophic limit on out-of-pocket expenses

An MA regional plan shall include the following:

(1) Single deductible

Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

(2) Catastrophic limit

(A) In-network

A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

(B) Total

A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

(c) Portion of total payments to an organization subject to risk for 2006 and 2007

(1) Application of risk corridors

(A) In general

This subsection shall only apply to MA regional plans offered during 2006 or 2007.

(B) Notification of allowable costs under the plan

In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees

under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

(C) Allowable costs defined

For purposes of this subsection, the term ''allowable costs'' means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

(D) Rebatable integrated benefits

For purposes of this subsection, the term ''rebatable integrated benefits'' means such non-drug supplemental benefits under subclause (I) of section 1395w–24(b)(1)(C)(ii) of this title pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

(2) Adjustment of payment

(A) No adjustment if allowable costs within 3 percent of target amount

If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

(B) Increase in payment if allowable costs above 103 percent of target amount

(i) Costs between 103 and 108 percent of target amount

If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

(ii) Costs above 108 percent of target amount

If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

(C) Reduction in payment if allowable costs below 97 percent of target amount

(i) Costs between 92 and 97 percent of target amount

If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

(ii) Costs below 92 percent of target amount

If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1395w–23(a) of this title by an amount (or otherwise recover from the plan an amount) equal to the sum of—

(I) 2.5 percent of such target amount; and

(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

(D) Target amount described

For purposes of this paragraph, the term ''target amount'' means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

(i) the sum of—

(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title);

(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

(III) the total amount of the rebates under section 1395w–24(b)(1)(C)(ii) of this title that are attributable to rebatable integrated benefits; reduced by

(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

(3) Disclosure of information

(A) In general

Each contract under this part shall provide—

(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

(ii) that, pursuant to section 1395w–27(d)(2)(B) of this title, the Secretary has the right to inspect and audit any books and records of the organization

that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

(B) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

(d) Organizational and financial requirements

(1) In general

In the case of an MA organization that is offering an MA regional plan in an MA region and—

(A) meets the requirements of section 1395w–25(a)(1) of this title with respect to at least one such State in such region; and

(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

(2) Selection of appropriate State

In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1395w–25(a)(1) of this title with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

(e) Repealed. Pub. L. 111–148, title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 964

(f) Computation of applicable MA region-specific non-drug monthly benchmark amounts

(1) Computation for regions

For purposes of section 1395w–23(j)(2) of this title and this section, subject to subsection (e) of this section, the term ''MA region-specific non-drug monthly benchmark amount'' means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1395w–21(e)(3)(B) of this title for each year (beginning with 2006).

(2) 2 components

For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

(A) Statutory component

The product of the following:

(i) Statutory region-specific non-drug amount

The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

(ii) Statutory national market share

The statutory national market share percentage, determined under paragraph (4) for the year.

(B) Plan-bid component

The product of the following:

(i) Weighted average of MA plan bids in region

The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

(ii) Non-statutory market share

1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

(3) Statutory region-specific non-drug amount

For purposes of paragraph (2)(A)(i), the term ''statutory region-specific non-drug amount'' means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

(A) MA area-specific non-drug monthly benchmark amount under section 1395w–23(j)(1)(A) of this title for that area and year; and

(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

(4) Computation of statutory market share percentage

(A) In general

The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

(B) Reference month defined

For purposes of this part, the term ''reference month'' means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(5) Determination of weighted average MA bids for a region

(A) In general

For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) Monthly MA statutory non-drug bid amount

The unadjusted MA statutory non-drug monthly bid amount for the plan.

(ii) Plan's share of MA enrollment in region

The factor described in subparagraph (B) for the plan.

(B) Plan's share of MA enrollment in region

(i) In general

Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

(ii) Single plan rule

In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) Equal division among multiple plans in year in which plans are first available

In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) 1 divided by the number of such plans offered in such year; or

(II) a factor for such plan that is based upon the organization's estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(C) Counting of individuals

For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) Plans covered

For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) Election of uniform coverage determination

Instead of applying section 1395w–22(a)(2)(C) of this title with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) Assuring network adequacy

(1) In general

For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1395w–22 of this title with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1395ww of this title with respect to such services; and

(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital's costs of such services exceed the payment amount described in subparagraph (A).

(2) Payment amounts

The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

(A) the amount of payment that would have been paid for such services under this subchapter if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

(B) the amount of payment made for such services under paragraph (1)(A).

(3) Available amounts

There shall be available for payments under this subsection—

(A) in 2006, $25,000,000; and

(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1395ww(b)(3)(B)(iii) of this title) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

(4) Essential hospital

In this subsection, the term ''essential hospital'' means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1395ww(d) of this title) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

(Aug. 14, 1935, ch. 531, title XVIII, § 1858, as added Pub. L. 108–173, title II, § 221(c), Dec. 8, 2003, 117 Stat. 2181; amended Pub. L. 109–432, div. B, title III, § 301, Dec. 20, 2006, 120 Stat. 2990; Pub. L. 110–48, § 3, July 18, 2007, 121 Stat. 244; Pub. L. 110–173, title I, § 110, Dec. 29, 2007, 121 Stat. 2497; Pub. L. 110–275, title I, § 166, July 15, 2008, 122 Stat. 2575; Pub. L. 111–8, div. G, title I, § 1301(f),

Mar. 11, 2009, 123 Stat. 829; Pub. L. 111–148, title III, § 3201(a)(2)(C), (f)(2), title X, § 10327(c)(1), Mar. 23, 2010, 124 Stat. 444, 450, 964; Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.)

AMENDMENTS

2010—Subsec. (e). Pub. L. 111–148, § 10327(c)(1), struck out subsec. (e) which related to the MA Regional Plan Stabilization Fund.

Subsec. (f)(1). Pub. L. 111–148, § 3201(a)(2)(C)(i), (f)(2)(A), which directed substitution of ''1395w–23(j)(1)(B)'' for ''1395w–23(j)(2)'' and ''subsections (e) and (i)'' for ''subsection (e)'', respectively, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (f)(3)(A). Pub. L. 111–148, § 3201(a)(2)(C)(ii), which directed substitution of ''1395w–23(j)(1)(A)(i)'' for ''1395w–23(j)(1)(A)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (i). Pub. L. 111–148, § 3201(f)(2)(B), which directed addition of subsec. (i), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows: ''For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1395w–23(n) of this title (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.'' See Effective Date of 2010 Amendment note below.

2009—Subsec. (e)(7). Pub. L. 111–8 struck out par. (7) which related to biennial GAO reports to be submitted by the Comptroller General to the Secretary and Congress.

2008—Subsec. (e)(2)(A)(i). Pub. L. 110–275 substituted ''2014'' for ''2013'' and ''$1'' for ''$1,790,000,000''.

2007—Subsec. (e)(2)(A)(i). Pub. L. 110–173, which directed substitution of ''the Fund during 2013, $1,790,000,000.'' for ''the Fund'' and all that follows, was executed by making the substitution for ''the Fund—

''(I) during 2012, $1,600,000,000; and

''(II) during 2013, $1,790,000,000.''

to reflect the probable intent of Congress.

Pub. L. 110–48 substituted ''the Fund—

''(I) during 2012, $1,600,000,000; and

''(II) during 2013, $1,790,000,000.''

for ''the Fund during the period beginning on January 1, 2012, and ending on December 31, 2013, a total of $3,500,000,000.''

2006—Subsec. (e)(2)(A)(i). Pub. L. 109–432 substituted ''2012'' for ''2007'' and ''$3,500,000,000'' for ''$10,000,000,000''.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND; TRANSITION

Pub. L. 111–148, title X, § 10327(c)(2), Mar. 23, 2010, 124 Stat. 964, provided that: ''Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act [Mar. 23, 2010] shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.''

§ 1395w–28. Definitions; miscellaneous provisions

(a) Definitions relating to Medicare+Choice organizations

In this part—

(1) Medicare+Choice organization

The term ''Medicare+Choice organization'' means a public or private entity that is certified under section 1395w–26 of this title as meeting the requirements and standards of this part for such an organization.

(2) Provider-sponsored organization

The term ''provider-sponsored organization'' is defined in section 1395w–25(d)(1) of this title.

(b) Definitions relating to Medicare+Choice plans

(1) Medicare+Choice plan

The term ''Medicare+Choice plan'' means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1395w–27 of this title.

(2) Medicare+Choice private fee-for-service plan

The term ''Medicare+Choice private fee-for-service plan'' means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA plan

(A) In general

The term ''MSA plan'' means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1395w–22(a)(1) of this title in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B of this subchapter, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—