

(iv) acknowledges that Medigap plans under section 1395ss of this title do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this subchapter; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this subchapter.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1320a-7 of this title.

(3) Physician or practitioner requirements

(A) In general

Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) Affidavit

An affidavit is described in this subparagraph if—

(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this subchapter for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and

(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(C) Enforcement

If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this subchapter for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

(ii) no payment shall be made under this subchapter for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

(4) Limitation on actual charge and claim submission requirement not applicable

Section 1395w-4(g) of this title shall not apply with respect to any item or service pro-

vided to a medicare beneficiary under a contract described in paragraph (1).

(5) Definitions

In this subsection:

(A) Medicare beneficiary

The term “medicare beneficiary” means an individual who is entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter.

(B) Physician

The term “physician” has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1395x(r) of this title.

(C) Practitioner

The term “practitioner” has the meaning given such term by section 1395u(b)(18)(C) of this title.

(Aug. 14, 1935, ch. 531, title XVIII, §1802, as added Pub. L. 89-97, title I, §102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 105-33, title IV, §4507(a)(1), (2)(A), Aug. 5, 1997, 111 Stat. 439, 441; Pub. L. 108-173, title VI, §603, Dec. 8, 2003, 117 Stat. 2301.)

AMENDMENTS

2003—Subsec. (b)(5)(B). Pub. L. 108-173 substituted “paragraphs (1), (2), (3), and (4) of section 1395x(r)” for “section 1395x(r)(1)”.

1997—Pub. L. 105-33 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105-33, title IV, §4507(c), Aug. 5, 1997, 111 Stat. 442, provided that: “The amendment made by subsection (a) [amending this section and section 1395y of this title] shall apply with respect to contracts entered into on and after January 1, 1998.”

REPORT TO CONGRESS ON EFFECT OF PRIVATE CONTRACTS

Pub. L. 105-33, title IV, §4507(b), Aug. 5, 1997, 111 Stat. 441, provided that: “Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title [see Tables for classification] of private contracts entered into under the amendment made by subsection (a) [amending this section and section 1395y of this title]. Such report shall include—

“(1) analyses regarding—

“(A) the fiscal impact of such contracts on total Federal expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and on out-of-pocket expenditures by medicare beneficiaries for health services under such title; and

“(B) the quality of the health services provided under such contracts; and

“(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act [42 U.S.C. 1395a(b)] (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.”

§ 1395b. Option to individuals to obtain other health insurance protection

Nothing contained in this subchapter shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

(Aug. 14, 1935, ch. 531, title XVIII, §1803, as added Pub. L. 89-97, title I, §102(a), July 30, 1965, 79 Stat. 291.)

IMPACT OF INCREASED INVESTMENTS IN HEALTH
RESEARCH ON FUTURE MEDICARE COSTS

Pub. L. 105-78, title II, Nov. 13, 1997, 111 Stat. 1484, provided in part: "That in carrying out its legislative mandate, the National Bipartisan Commission on the Future of Medicare shall examine the impact of increased investments in health research on future Medicare costs, and the potential for coordinating Medicare with cost-effective long-term care services".

NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF
MEDICARE

Pub. L. 105-33, title IV, §4021, Aug. 5, 1997, 111 Stat. 347, established National Bipartisan Commission on the Future of Medicare which was directed to review and analyze long-term financial condition of medicare program, identify problems that threaten financial integrity of Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund, analyze potential solutions that will ensure both financial integrity of medicare program and provision of appropriate benefits under such program, and make recommendations for, among other things, restoring solvency of Federal Hospital Insurance Trust Fund and financial integrity of Federal Supplementary Medical Insurance Trust Fund, establishing appropriate financial structure of medicare program as a whole, and establishing appropriate balance of benefits covered and beneficiary contributions to medicare program, further provided for membership of Commission, meetings, personnel and staff matters, powers of Commission, appropriations, submission of final report to Congress not later than Mar. 1, 1999, and termination of Commission 30 days after submission of final report.

EXCLUSION FROM WAGES AND COMPENSATION OF RE-
FUNDS REQUIRED FROM EMPLOYERS TO COMPENSATE
FOR DUPLICATION OF MEDICARE BENEFITS BY HEALTH
CARE BENEFITS PROVIDED BY EMPLOYERS

Pub. L. 101-239, title X, §10202, Dec. 19, 1989, 103 Stat. 2473, provided that:

"(a) OLD-AGE, SURVIVORS, AND DISABILITY, AND HOSPITAL INSURANCE PROGRAMS.—For purposes of title II of the Social Security Act [42 U.S.C. 401 et seq.] and chapter 21 of the Internal Revenue Code of 1986 [26 U.S.C. 3101 et seq.], the term 'wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 [section 421 of Pub. L. 100-360, formerly set out as a note below].

"(b) RAILROAD RETIREMENT PROGRAM.—For purposes of chapter 22 of the Internal Revenue Code of 1986 [26 U.S.C. 3201 et seq.], the term 'compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

"(c) FEDERAL UNEMPLOYMENT PROGRAMS.—

"(1) FEDERAL UNEMPLOYMENT TAX.—For purposes of chapter 23 of the Internal Revenue Code of 1986 [26 U.S.C. 3301 et seq.], the term 'wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

"(2) RAILROAD UNEMPLOYMENT CONTRIBUTIONS.—For purposes of the Railroad Unemployment Insurance Act [45 U.S.C. 351 et seq.], the term 'compensation' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

"(3) RAILROAD UNEMPLOYMENT REPAYMENT TAX.—For purposes of chapter 23A of the Internal Revenue Code of 1986 [26 U.S.C. 3321 et seq.], the term 'rail wages' shall not include the amount of any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988.

"(d) REPORTING REQUIREMENTS.—Any refund required under section 421 of the Medicare Catastrophic Coverage Act of 1988 shall be reported to the Secretary of the Treasury or his delegate and to the person to whom such refund is made in such manner as the Secretary of the Treasury or his delegate shall prescribe.

"(e) EFFECTIVE DATE.—This section shall apply with respect to refunds provided on or after January 1, 1989."

UNITED STATES BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE

Pub. L. 100-360, title IV, subtitle A, §§401-408, July 1, 1988, 102 Stat. 765-768, as amended by Pub. L. 100-647, title VIII, §8414, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101-239, title VI, §6220, Dec. 19, 1989, 103 Stat. 2254, established the United States Bipartisan Commission on Comprehensive Health Care, also known as the "Claude Pepper Commission" or the "Pepper Commission", and directed Commission to examine shortcomings in health care delivery and financing mechanisms that limit or prevent access of all individuals in United States to comprehensive health care, and make specific recommendations respecting Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for elderly and disabled, as well as comprehensive health care services for all individuals in the United States, and further provided for membership of Commission, staff and consultants, powers, authorization of appropriations, submission of findings and recommendations to Congress not later than Nov. 9, 1989, and for termination of Commission 30 days after submissions to Congress.

MAINTENANCE OF EFFORT REGARDING DUPLICATIVE
BENEFITS

Pub. L. 100-360, title IV, §421, July 1, 1988, 102 Stat. 808, as amended by Pub. L. 100-485, title VI, §608(a), Oct. 13, 1988, 102 Stat. 2411, which required employers who had been providing health care benefits to employees that were duplicative part A and part B benefits to provide the employees with additional benefits equal to the total actuarial value of such duplicative benefits, was repealed by Pub. L. 101-234, title III, §301(a), Dec. 13, 1989, 103 Stat. 1985. [Repeal not applicable to duplicative part A benefits for periods before Jan. 1, 1990, see section 301(e)(1) of Pub. L. 101-234, set out as an Effective Date of 1989 Amendment note under section 1395u of this title.]

TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

Pub. L. 99-272, title IX, §9601, Apr. 7, 1986, 100 Stat. 221, as amended by Pub. L. 105-362, title VI, §601(b)(3), Nov. 10, 1998, 112 Stat. 3286, directed Secretary of Health and Human Services, in consultation with National Association of Insurance Commissioners, to establish Task Force on Long-Term Health Care Policies to develop recommendations for long-term health care policies designed to limit marketing and agent abuse for those policies, to assure dissemination of such information to consumers as is necessary to permit informed choice in purchasing policies and to reduce purchase of unnecessary or duplicative coverage, to assure that benefits provided under policies are reasonable in relationship to premiums charged, and to promote development and availability of long-term health care policies which meet these recommendations, and further provided for composition of Task Force, definition of long-term health care policy, assurance of States' jurisdiction, submission of recommendations to Secretary and Congress not later than 18 months after Apr. 7, 1986, and termination of Task Force 90 days after submission of recommendations.

§ 1395b-1. Incentives for economy while maintaining or improving quality in provision of health services

(a) Grants and contracts to develop and engage in experiments and demonstration projects

(1) The Secretary of Health and Human Services is authorized, either directly or through grants to public or private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organiza-