''(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

''(c) PROJECT IMPLEMENTATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

''(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

''(i) establish the benefit design among plans offered in such area,

''(ii) structure the method for selecting plans offered in such area; and

''(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

''(B) in consultation with such Committee—

''(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

''(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

''(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

''(d) MONITORING AND REPORT.—

''(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

''(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

''(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act [this subchapter] (as amended by this Act) as may be necessary for the purposes of carrying out the project.

''(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

''(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001 [enacting this part and redesignating former part C of this subchapter as part D], if the project had not been conducted.

''(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act [this part], as amended by section 4001, shall have the same meaning as when used in such part.

''SEC. 4012. ADVISORY COMMITTEES.

''(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

''(1) IN GENERAL.—Before implementing the project under this subchapter [subchapter A (§§ 4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33], the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

''(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

''(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

''(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

''(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

''(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

''(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.''

§ 1395w–24. Premiums and bid amounts

(a) Submission of proposed premiums, bid amounts, and related information

(1) In general

(A) Initial submission

Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the

Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

(ii) The plan type for each plan.

(iii) The enrollment capacity (if any) in relation to the plan and area.

(B) Beneficiary rebate information

In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

(C) Paperwork reduction for offering of MA regional plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) Information required for coordinated care plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

(3) Requirements for MSA plans

For an MSA plan for any year, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the Medicare+Choice monthly supplementary beneficiary premium.

(4) Requirements for private fee-for-service plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(C) of this title for benefits described in section 1395w–22(a)(1)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the amount of the Medicare+Choice monthly basic beneficiary premium;

(iii) a description of the deductibles, coinsurance, and copayments applicable under the plan, and the actuarial value of such deductibles, coinsurance, and copayments, as described in subsection (e)(4)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

(5) Review

(A) In general

Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under paragraphs (2) and (4) of this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare & Medicaid Services shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) Exception

The Secretary shall not review, approve, or disapprove the amounts submitted under

paragraph (3) or, in the case of an MA private fee-for-service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

(C) Rejection of bids

(i) In general

Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

(ii) Authority to deny bids that propose significant increases in cost sharing or decreases in benefits

The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(6) Submission of bid amounts by MA organizations beginning in 2006

(A) Information to be submitted

For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 300e–1(8) of this title) in the payment area for an enrollee with a national average risk profile for the factors described in section 1395w–23(a)(1)(C) of this title (as specified by the Secretary).

(ii) The proportions of such bid amount that are attributable to—

(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title), including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title;

(II) the provision of basic prescription drug coverage; and

(III) the provision of supplemental health care benefits.

(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A).

(v) With respect to qualified prescription drug coverage, the information required under section 1395w–104 of this title, as incorporated under section 1395w–111(b)(2) of this title, with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) Acceptance and negotiation of bid amounts

(i) Authority

Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5.

(ii) Application of FEHBP standard

Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 300e–1(8) of this title) of benefits provided under that plan.

(iii) Noninterference

In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

(iv) Exception

In the case of a plan described in section 1395w–21(a)(2)(C) of this title, the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).

(b) Monthly premium charged

(1) In general

(A) Rule for other than MSA plans

Subject to the rebate under subparagraph (C), the monthly amount (if any) of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly supplementary beneficiary premium (if any), and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium.

(B) MSA plans

The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a Medicare+Choice organization shall be equal to the Medicare+Choice monthly supplemental beneficiary premium (if any).

(C) Beneficiary rebate rule

(i) Requirement

The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent (or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012) of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

(ii) Form of rebate for plan years before 2012

For plan years before 2012, a rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

(I) Provision of supplemental health care benefits and payment for premium for supplemental benefits

The provision of supplemental health care benefits described in section 1395w–22(a)(3) of this title in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

(II) Payment for premium for prescription drug coverage

Crediting toward the MA monthly prescription drug beneficiary premium.

(III) Payment toward part B premium

Crediting toward the premium imposed under part B (determined without regard to the application of subsections (b), (h), and (i) of section 1395r of this title).

(iii) Applicable rebate percentage

The applicable rebate percentage specified in this clause for a plan for a year, based on the system under section 1395w–23(*o*)(4)(A), is the sum of—

(I) the product of the old phase-in proportion for the year under clause (iv) and 75 percent; and

(II) the product of the new phase-in proportion for the year under clause (iv) and the final applicable rebate percentage under clause (v).

(iv) Old and new phase-in proportions

For purposes of clause (iv)—

(I) for 2012, the old phase-in proportion is ⅔ and the new phase-in proportion is ⅓;

(II) for 2013, the old phase-in proportion is ⅓ and the new phase-in proportion is ⅔; and

(III) for 2014 and any subsequent year, the old phase-in proportion is 0 and the new phase-in proportion is 1.

(v) Final applicable rebate percentage

Subject to clause (vi), the final applicable rebate percentage under this clause is—

(I) in the case of a plan with a quality rating under such system of at least 4.5 stars, 70 percent;

(II) in the case of a plan with a quality rating under such system of at least 3.5 stars and less than 4.5 stars, 65 percent; and

(III) in the case of a plan with a quality rating under such system of less than 3.5 stars, 50 percent.

(vi) Treatment of low enrollment and new plans

For purposes of clause (v)—

(I) for 2012, in the case of a plan described in subclause (I) of subsection (*o*)(3)(A)(ii),[1] the plan shall be treated as having a rating of 4.5 stars; and

(II) for 2012 or a subsequent year, in the case of a new MA plan (as defined under subclause (III) of subsection (*o*)(3)(A)(iii)[2]) that is treated as a qualifying plan pursuant to subclause (I) of such subsection, the plan shall be treated as having a rating of 3.5 stars.

(vii) Disclosure relating to rebates

The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

(viii) Application of part B premium reduction

Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(2) Premium and bid terminology defined

For purposes of this part:

(A) MA monthly basic beneficiary premium

The term ''MA monthly basic beneficiary premium'' means, with respect to an MA plan—

(i) described in section 1395w–23(a)(1)(B)(i) of this title (relating to plans providing rebates), zero; or

(ii) described in section 1395w–23(a)(1)(B)(ii) of this title, the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA

[1] So in original. Probably means subclause (I) of section 1395w–23(*o*)(3)(A)(ii) of this title.

[2] So in original. Probably means subclause (II) of section 1395w–23(*o*)(3)(A)(iii) of this title.

area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j) of this title).

(B) MA monthly prescription drug beneficiary premium

The term ''MA monthly prescription drug beneficiary premium'' means, with respect to an MA plan, the base beneficiary premium (as determined under section 1395w–113(a)(2) of this title and as adjusted under section 1395w–113(a)(1)(B) of this title), less the amount of rebate credited toward such amount under subsection (b)(1)(C)(ii)(II).

(C) MA monthly supplemental beneficiary premium

(i) In general

The term ''MA monthly supplemental beneficiary premium'' means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under subsection (b)(1)(C)(ii)(I).

(ii) Application of MA monthly supplementary beneficiary premium

For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).[3]

(D) Medicare+Choice monthly MSA premium

The term ''Medicare+Choice monthly MSA premium'' means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

(E) Unadjusted MA statutory non-drug monthly bid amount

The term ''unadjusted MA statutory non-drug monthly bid amount'' means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1395w–22(a)(1)(B) of this title).

(3) Computation of average per capita monthly savings for local plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA local plan and year is computed as follows:

(A) Determination of statewide average risk adjustment for local plans

(i) In general

Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each State, the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that State for MA local plans.

(ii) Treatment of States for first year in which local plan offered

In the case of a State in which no MA local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable States or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than States

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than States or on a plan-specific basis.

(B) Determination of risk adjusted benchmark and risk-adjusted bid for local plans

For each MA plan offered in a local area in a State, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(1) of this title) for the area by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA local plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(4) Computation of average per capita monthly savings for regional plans

For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA regional plan and year is computed as follows:

(A) Determination of regionwide average risk adjustment for regional plans

(i) In general

The Secretary shall determine, at the same time rates are promulgated under section 1395w–23(b)(1) of this title (beginning with 2006) for each MA region the average of the risk adjustment factors to be applied under section 1395w–23(a)(1)(C) of this title to payment for enrollees in that region for MA regional plans.

(ii) Treatment of regions for first year in which regional plan offered

In the case of an MA region in which no MA regional plan was offered in the pre-

[3] See References in Text note below.

vious year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable regions or applied on a national basis.

(iii) Authority to determine risk adjustment for areas other than regions

The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than MA regions or on a plan-specific basis.

(B) Determination of risk-adjusted benchmark and risk-adjusted bid for regional plans

For each MA regional plan offered in a region, the Secretary shall—

(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1395w–23(j)(2) of this title) for the region by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) Determination of average per capita monthly savings

The average per capita monthly savings described in this subparagraph for an MA regional plan is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(c) Uniform premium and bid amounts

Except as permitted under section 1395w–27(i) of this title, the MA monthly bid amount submitted under subsection (a)(6), the amounts of the MA monthly basic, prescription drug, and supplemental beneficiary premiums, and the MA monthly MSA premium charged under subsection (b) of an MA organization under this part may not vary among individuals enrolled in the plan.

(d) Terms and conditions of imposing premiums

(1) In general

Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic, prescription drug, and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1395w–21(g)(3)(B)(i) of this title, and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Beneficiary's option of payment through withholding from social security payment or use of electronic funds transfer mechanism

In accordance with regulations, an MA organization shall permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(A) withholding from benefit payments in the manner provided under section 1395s of this title with respect to monthly premiums under section 1395r of this title;

(B) an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); or

(C) such other means as the Secretary may specify, including payment by an employer or under employment-based retiree health coverage (as defined in section 1395w–132(c)(1) of this title) on behalf of an employee or former employee (or dependent).

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this subchapter and shall be paid to the MA organization involved. No charge may be imposed under an MA plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

(3) Information necessary for collection

In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

(A) by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium described in paragraph (4) owed by such enrollee for each month during the year, and other information determined appropriate by the Secretary, in consultation with the Commissioner of Social Security; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(4) Consolidated monthly beneficiary premium

In the case of an enrollee in an MA plan, the Secretary shall provide a mechanism for the consolidation of—

(A) the MA monthly basic beneficiary premium (if any);

(B) the MA monthly supplemental beneficiary premium (if any); and

(C) the MA monthly prescription drug beneficiary premium (if any).

(e) Limitation on enrollee liability

(1) For basic and additional benefits before 2006

For periods before 2006, in no event may—

(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in

section 1395w–21(a)(2)(A) of this title of an organization with respect to required benefits described in section 1395w–22(a)(1)(A) of this title and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(2) For supplemental benefits before 2006

For periods before 2006, if the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title with respect to supplemental benefits described in section 1395w–22(a)(3) of this title, the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

(3) Determination on other basis

If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A), (2), or (4), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

(4) Special rule for private fee-for-service plans and for basic benefits beginning in 2006

With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan) and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title, in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to benefits under the original medicare fee-for-service program option, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable with respect to such benefits on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

(f) Requirement for additional benefits before 2006

(1) Requirement

(A) In general

For years before 2006, each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) Excess amount

For purposes of this paragraph, the ''excess amount'', for an organization for a plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1395w–23 of this title for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1395w–22(a)(1)(A) of this title under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

(C) Adjusted excess amount

For purposes of this paragraph, the ''adjusted excess amount'', for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) Uniform application

This paragraph shall be applied uniformly for all enrollees for a plan.

(E) Premium reductions

(i) In general

Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1395w–23(a)(1)(A) of this title with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1395r of this title of each enrollee in such plan as provided in section 1395s(i) of this title.

(ii) Amount of reduction

The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

(I) may not exceed 125 percent of the premium described under section 1395r(a)(3) of this title; and

(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

(F) Construction

Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1395w–22(a)(3) of this title) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) Stabilization fund

A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) Adjusted community rate

For purposes of this subsection, subject to paragraph (4), the term ''adjusted community rate'' for a service or services means, at the election of a Medicare+Choice organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a ''community rating system'' (as defined in section 300e–1(8) of this title, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Determination based on insufficient data

For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

(g) Prohibition of State imposition of premium taxes

No State may impose a premium tax or similar tax with respect to payments to Medicare+Choice organizations under section 1395w–23 of this title or premiums paid to such organizations under this part.

(h) Permitting use of segments of service areas

The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.

(Aug. 14, 1935, ch. 531, title XVIII, § 1854, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 308; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(C), title V, §§ 515(a), 516(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–367, 1501A–384; Pub. L. 106–554, § 1(a)(6) [title VI, §§ 606(a)(1), 622(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–557, 2763A–566; Pub. L. 107–188, title V, § 532(b)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title II, §§ 222(a)(1), (b), (c), (g), 232(b), title IX, § 900(e)(1)(H), Dec. 8, 2003, 117 Stat. 2193, 2196, 2199, 2203, 2208, 2371; Pub. L. 111–148, title III, §§ 3201(a)(2)(B), (c)–(d)(2), (e)(2)(A)(v), 3202(b)(1), (3), 3209(a), Mar. 23, 2010, 124 Stat. 444, 447, 454, 455, 460; Pub. L. 111–152, title I, § 1102(a), (d), Mar. 30, 2010, 124 Stat. 1040, 1045; Pub. L. 115–123, div. E, title III, § 50323(b), Feb. 9, 2018, 132 Stat. 203.)

REFERENCES IN TEXT

Cl. (iii) of par. (1)(C), referred to in subsec. (b)(2)(C)(ii), was struck out and a new cl. (iii) was added by Pub. L. 111–152, § 1102(d)(2). See 2010 Amendment note below. As so amended, par. (1)(C)(iii) no longer relates to purposes of rebates and no longer contains a subcl. (III).

AMENDMENTS

2018—Subsec. (a)(6)(A)(ii)(I). Pub. L. 115–123 inserted '', including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1395w–22(m) of this title'' before semicolon at end.

2010—Subsec. (a)(5)(C). Pub. L. 111–148, § 3209(a), added subpar. (C).

Subsec. (a)(6)(A). Pub. L. 111–148, § 3201(d)(1), which directed insertion of ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).'' at end of concluding provisions, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(i). Pub. L. 111–148, § 3201(d)(2)(A), which directed substitution of ''(iii), (iv), and (v)'' for ''(iii) and (iv)'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(6)(B)(v). Pub. L. 111–148, § 3201(d)(2)(B), which directed addition of cl. (v), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1395w–23(j)(1)(A)(i) of this title, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

''(aa) actuarial guidelines for the submission of bid information under this paragraph; and

''(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

''(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

''(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(i). Pub. L. 111–152, §1102(d)(1), inserted ''(or the applicable rebate percentage specified in clause (iii) in the case of plan years beginning on or after January 1, 2012)'' after ''75 percent''.

Pub. L. 111–148, §3201(c), which directed insertion of ''(or 100 percent in the case of plan years beginning on or after January 1, 2014)'' after ''75 percent'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(C)(ii). Pub. L. 111–148, §3202(b)(1)(A), substituted ''rebate for plan years before 2012'' for ''rebate'' in heading and ''For plan years before 2012, a rebate'' for ''A rebate'' in introductory provisions.

Subsec. (b)(1)(C)(iii). Pub. L. 111–152, §1102(d)(2), added cl. (iii) and struck out former cl. (iii). Prior to amendment, text read as follows: ''For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

''(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

''(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

''(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).''

Pub. L. 111–148, §3202(b)(1)(C), added cl. (iii).

Subsec. (b)(1)(C)(iv). Pub. L. 111–152, §1102(d)(2), added cl. (iv). Former cl. (iv) redesignated (vii).

Pub. L. 111–148, §3202(b)(1)(B), redesignated cl. (iii) as (iv).

Subsec. (b)(1)(C)(v). Pub. L. 111–152, §1102(d)(2), added cl. (v). Former cl. (v) redesignated (viii).

Pub. L. 111–148, §3202(b)(1)(B), redesignated cl. (iv) as (v).

Subsec. (b)(1)(C)(vi) to (viii). Pub. L. 111–152, §1102(d)(2), added cl. (vi) and redesignated cls. (iv) and (v) as (vii) and (viii), respectively.

Subsec. (b)(2)(C). Pub. L. 111–148, §3202(b)(3), designated existing text as cl. (i), inserted cl. (i) heading, and added cl. (ii).

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

Subsec. (b)(4)(B)(i). Pub. L. 111–148, §3201(a)(2)(B)(ii), which directed substitution of ''1395w–23(j)(1)(B)'' for ''1395w–23(j)(2)'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (h). Pub. L. 111–148, §3201(e)(2)(A)(v), which directed repeal of subsec. (h), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

2003—Pub. L. 108–173, §222(g)(1)(A), substituted ''Premiums and bid amounts'' for ''Premiums'' in section catchline.

Subsec. (a). Pub. L. 108–173, §222(g)(1)(B), inserted '', bid amounts,'' after ''premiums'' in heading.

Subsec. (a)(1). Pub. L. 108–173, §222(a)(1)(A), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: ''Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year), each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h) of this section) in which it intends to be offered in the following year—

''(A) the information described in paragraph (2), (3), or (4) for the type of plan involved; and

''(B) the enrollment capacity (if any) in relation to the plan and area.''

Subsec. (a)(2). Pub. L. 108–173, §222(g)(1)(C), inserted ''before 2006'' after ''for coordinated care plans'' in heading and ''for a year before 2006'' after ''section 1395w–21(a)(2)(A) of this title'' in introductory provisions.

Subsec. (a)(3). Pub. L. 108–173, §222(g)(1)(D), substituted ''For an MSA plan for any year'' for ''For an MSA plan described'' in introductory provisions.

Subsec. (a)(4). Pub. L. 108–173, §222(g)(1)(E), inserted ''before 2006'' after ''for private fee-for-service plans'' in heading and ''for a year before 2006'' after ''section 1395w–22(a)(1)(A) of this title'' in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 108–173, §900(e)(1)(H), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Pub. L. 108–173, §222(g)(1)(F), inserted ''paragraphs (2) and (4) of'' after ''filed under''.

Subsec. (a)(5)(B). Pub. L. 108–173, §222(g)(1)(G), inserted '', in the case of an MA private fee-for-service plan,'' after ''paragraph (3) or''.

Subsec. (a)(6). Pub. L. 108–173, §222(a)(1)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108–173, §222(b)(1)(A), (g)(1)(H), substituted ''Subject to the rebate under subparagraph (C), the monthly amount (if any)'' for ''The monthly amount'' and a comma for ''and'' after ''basic beneficiary premium'' and inserted before period at end '', and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium''.

Subsec. (b)(1)(C). Pub. L. 108–173, §222(b)(1)(B), added subpar. (C).

Subsec. (b)(2). Pub. L. 108–173, §222(b)(2), inserted ''and bid'' after ''Premium'' in heading, added subpars. (A) to (C) and (E), redesignated former subpar. (C) as (D), and struck out former subpars. (A) and (B) which defined the terms ''Medicare+Choice monthly basic beneficiary premium'' and ''Medicare+Choice monthly supplemental beneficiary premium''.

Subsec. (b)(3), (4). Pub. L. 108–173, §222(b)(3), added pars. (3) and (4).

Subsec. (c). Pub. L. 108–173, §222(g)(2), amended heading and text of subsec. (c) generally. Prior to amend-

ment, text read as follows: ''The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of this section of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.''

Subsec. (d). Pub. L. 108–173, § 222(c), (g)(3), designated existing provisions as par. (1), inserted heading and '', prescription drug,'' after ''basic'', and added pars. (2) to (4).

Subsec. (e)(1). Pub. L. 108–173, § 222(g)(4)(A), inserted ''before 2006'' after ''benefits'' in heading and substituted ''For periods before 2006, in'' for ''In'' in introductory provisions.

Subsec. (e)(2). Pub. L. 108–173, § 222(g)(4)(B), inserted ''before 2006'' after ''benefits'' in heading and substituted ''For periods before 2006, if'' for ''If'' in text.

Subsec. (e)(3). Pub. L. 108–173, § 222(g)(4)(C), substituted '', (2), or (4)'' for ''or (2)''.

Subsec. (e)(4). Pub. L. 108–173, § 222(g)(4)(D)(i), (ii), inserted ''and for basic benefits beginning in 2006'' after ''plans'' in heading and ''and for periods beginning with 2006, with respect to an MA plan described in section 1395w–21(a)(2)(A) of this title'' after ''MSA plan)'' in introductory provisions.

Subsec. (e)(4)(A). Pub. L. 108–173, § 222(g)(4)(D)(iii), substituted ''benefits under the original medicare fee-for-service program option'' for ''required benefits described in section 1395w–22(a)(1) of this title''.

Subsec. (e)(4)(B). Pub. L. 108–173, § 222(g)(4)(D)(iv), inserted ''with respect to such benefits'' after ''would be applicable''.

Subsec. (f). Pub. L. 108–173, § 222(g)(5)(A), inserted ''before 2006'' after ''additional benefits'' in heading.

Subsec. (f)(1)(A). Pub. L. 108–173, § 222(g)(5)(B), substituted ''For years before 2006, each'' for ''Each''.

Subsec. (g). Pub. L. 108–173, § 232(b), inserted ''or premiums paid to such organizations under this part'' after ''section 1395w–23 of this title''.

2002—Subsec. (a)(1). Pub. L. 107–188 substituted ''Not later than the second Monday in September of 2002, 2003, and 2004 (or July 1 of each other year)'' for ''Not later than July 1 of each year'' in introductory provisions.

2000—Subsec. (a)(5)(A). Pub. L. 106–554, § 1(a)(6) [title VI, § 622(a)], substituted ''values so submitted'' for ''value so submitted'' and inserted at end ''The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.''

Subsec. (f)(1)(E), (F). Pub. L. 106–554, § 1(a)(6) [title VI, § 606(a)(1)], added subpar. (E) and redesignated former subpar. (E) as (F).

1999—Subsec. (a)(1). Pub. L. 106–113, § 1000(a)(6) [title V, § 516(a)], substituted ''July 1'' for ''May 1'' in introductory provisions.

Pub. L. 106–113, § 1000(a)(6) [title V, § 515(a)(1)], inserted ''(or segment of such an area if permitted under subsection (h) of this section)'' after ''service area'' in introductory provisions.

Subsec. (a)(2)(A). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(i)(I)], inserted ''section'' before ''1395w–22(a)(1)(A) of this title'' in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(i)(II)], inserted ''section'' after ''described in'' in introductory provisions.

Subsec. (a)(3)(A), (B). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(ii)], inserted ''section'' after ''described in''.

Subsec. (a)(4). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(I)], which directed insertion of ''section'' after ''described in'', was executed by making the insertion after ''described in'' the second time appearing in introductory provisions to reflect the probable intent of Congress.

Subsec. (a)(4)(A). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(II)], inserted ''section'' after ''described in'' in introductory provisions.

Subsec. (a)(4)(B). Pub. L. 106–113, § 1000(a)(6) [title III, § 321(k)(6)(C)(iii)(III)], inserted ''section'' after ''described in''.

Subsec. (h). Pub. L. 106–113, § 1000(a)(6) [title V, § 515(a)(2)], added subsec. (h).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate 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.

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.

Pub. L. 111–148, title III, § 3201(d)(3), Mar. 23, 2010, 124 Stat. 445, which provided that amendments by section 3201(d) of Pub. L. 111–148 (amending this section) would apply to bid amounts submitted on or after Jan. 1, 2012, was repealed by Pub. L. 111–152, title I, § 1102(a), Mar. 30, 2010, 124 Stat. 1040.

Pub. L. 111–148, title III, § 3209(c), Mar. 23, 2010, 124 Stat. 460, provided that: ''The amendments made by this section [amending this section and section 1395w–111 of this title] shall apply to bids submitted for contract years beginning on or after January 1, 2011.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendment by section 222(a)(1), (b), (c), (g) of Pub. L. 108–173 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 a note under section 1395w–21 of this title.

Pub. L. 108–173, title II, § 232(c), Dec. 8, 2003, 117 Stat. 2209, provided that: ''The amendments made by this subsection [probably should be ''this section'', amending this section and section 1395w–26 of this title] shall take effect on the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 2002 AMENDMENT

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

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title VI, § 606(a)(1)] 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, § 622(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–566, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to submissions made on or after May 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(k)(6)(C)] 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, § 515(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''The amendments made by this section [amending this section] apply to contract years beginning on or after January 1, 2001.''

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 516(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''The amendment made by subsection (a) [amending this section] applies to information submitted by

Medicare+Choice organizations for years beginning with 1999.''

§ 1395w–25. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations

(a) Organized and licensed under State law

(1) In general

Subject to paragraphs (2) and (3), a Medicare+Choice organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan.

(2) Special exception for provider-sponsored organizations

(A) In general

In the case of a provider-sponsored organization that seeks to offer a Medicare+Choice plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary by not later than November 1, 2002, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) Failure to act on licensure application on a timely basis

The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before August 5, 1997, shall be included in determining such 90-day period.

(C) Denial of application based on discriminatory treatment

The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

(i) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business, or

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a Medicare+Choice plan.

(D) Denial of application based on application of solvency requirements

With respect to waiver applications filed on or after the date of publication of solvency standards under section 1395w–26(a) of this title, the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

(i) such requirements are not the same as the solvency standards established under section 1395w–26(a) of this title; or

(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this paragraph, the term ''solvency requirements'' means requirements relating to solvency and other matters covered under the standards established under section 1395w–26(a) of this title.

(E) Treatment of waiver

In the case of a waiver granted under this paragraph for a provider-sponsored organization with respect to a State—

(i) Limitation to State

The waiver shall be effective only with respect to that State and does not apply to any other State.

(ii) Limitation to 36-month period

The waiver shall be effective only for a 36-month period and may not be renewed.

(iii) Conditioned on compliance with consumer protection and quality standards

The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in subparagraph (G).

(iv) Preemption of State law

Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

(F) Prompt action on application

The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

(G) Application and enforcement of State consumer protection and quality standards

(i) In general

A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

(I) would apply in the State to the organization if it were licensed under State law;