solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.''

### § 1395a. Free choice by patient guaranteed

**(a) Basic freedom of choice**

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

**(b) Use of private contracts by medicare beneficiaries**

**(1) In general**

Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this subchapter, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this subchapter directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.

**(2) Beneficiary protections**

**(A) In general**

Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

(ii) the contract contains the items described in subparagraph (B); and

(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

**(B) Items required to be included in contract**

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this subchapter for such items or services even if such items or services are otherwise covered by this subchapter;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;

(iii) acknowledges that no limits under this subchapter (including the limits under section 1395w–4(g) of this title) apply to amounts that may be charged for such items or services;

(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 applicable 2-year period (as defined in subparagraph (D)); 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 applicable 2-year period (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).

**(D) Applicable 2-year periods for effectiveness of affidavits**

In this subsection, the term ''applicable 2-year period'' means, with respect to an affi-

davit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.

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

**(5) Posting of information on opt-out physicians and practitioners**

**(A) In general**

Beginning not later than February 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

**(B) Information to be included**

The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

(i) Their number.

(ii) Their physician or professional specialty or other designation.

(iii) Their geographic distribution.

(iv) The timing of their becoming opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled in the program under this subchapter and with respect to applicable 2-year periods.

(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.

**(6) Definitions**

In this subsection:

**(A) Medicare beneficiary**

The term ''medicare beneficiary'' means an individual who is entitled to benefits under part A or enrolled under part B.

**(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.

**(D) Opt-out physician or practitioner**

The term ''opt-out physician or practitioner'' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).

(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; Pub. L. 114–10, title I, § 106(a)(1)(A), (2), Apr. 16, 2015, 129 Stat. 137, 138.)

AMENDMENTS

2015—Subsec. (b)(3)(B)(ii). Pub. L. 114–10, § 106(a)(1)(A)(i), substituted ''during the applicable 2-year period (as defined in subparagraph (D))'' for ''during the 2-year period beginning on the date the affidavit is signed''.

Subsec. (b)(3)(C). Pub. L. 114–10, § 106(a)(1)(A)(ii), substituted ''during the applicable 2-year period'' for ''during the 2-year period described in subparagraph (B)(ii)'' in introductory provisions.

Subsec. (b)(3)(D). Pub. L. 114–10, § 106(a)(1)(A)(iii), added subpar. (D).

Subsec. (b)(5). Pub. L. 114–10, § 106(a)(2)(C), added par. (5). Former par. (5) redesignated (6).

Subsec. (b)(5)(D). Pub. L. 114–10, § 106(a)(2)(A), added subpar. (D).

Subsec. (b)(6). Pub. L. 114–10, § 106(a)(2)(B), redesignated par. (5) as (6).

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 2015 AMENDMENT

Pub. L. 114–10, title I, § 106(a)(1)(B), Apr. 16, 2015, 129 Stat. 138, provided that: ''The amendments made by subparagraph (A) [amending this section] shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act [Apr. 16, 2015].''

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.''

UPDATING THE WELCOME TO MEDICARE PACKAGE

Pub. L. 114–255, div. C, title XVII, § 17003, Dec. 13, 2016, 130 Stat. 1331, provided that:

''(a) IN GENERAL.—Not later than 12 months after the last day of the period for the request of information described in subsection (b), the Secretary of Health and Human Services shall, taking into consideration information collected pursuant to subsection (b), update the information included in the Welcome to Medicare package to include information, presented in a clear and simple manner, about options for receiving benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including through the original medicare fee-for-service program under parts A and B of such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et seq.), Medicare Advantage plans under part C of such title (42 U.S.C. 1395w–21 et seq.), and prescription drug plans under part D of such title (42 U.S.C. 1395w–101 et seq.)). The Secretary shall make subsequent updates to the information included in the Welcome to Medicare package as appropriate.

''(b) REQUEST FOR INFORMATION.—Not later than 6 months after the date of the enactment of this Act [Dec. 13, 2016], the Secretary of Health and Human Services shall request information, including recommendations, from stakeholders (including patient advocates, issuers, and employers) on information included in the Welcome to Medicare package, including

pertinent data and information regarding enrollment and coverage for Medicare eligible individuals.''

REPORT TO CONGRESS ON EFFECT OF PRIVATE CONTRACTS

Pub. L. 105–33, title IV, § 4507(b), Aug. 5, 1997, 111 Stat. 441, required a report to be submitted to Congress, no later than Oct. 1, 2001, on the effect on the program under title IV of Pub. L. 105–33 of certain private 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 REFUNDS 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 pur-