(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) (i) (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 provided 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.

References in Text

Parts A and B of this subchapter, referred to in subsec. (b)(5)(A), are classified to sections 1395c et seq. and 1395d et seq., respectively, of this title.

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)”.


Effective Date of 1997 Amendment

Section 4507(c) of Pub. L. 105–33 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

Section 4507(b) of title IV of Pub. L. 105–33 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 [this subchapter] 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 [subsec. (b) of this section] [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.


Impact of Increased Investments in Health Research on Future Medicare Costs


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 ap-
propriate 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 benefits 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 DULICATION OF MEDICARE BENEFITS BY HEALTH CARE BENEFITS PROVIDED BY EMPLOYERS


“(c) FEDERAL UNEMPLOYMENT PROGRAMS.—


“(2) RAILROAD UNEMPLOYMENT CONTRIBUTIONS.—For purposes of the Railroad Unemployment Insurance Act (45 U.S.C. 351 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.


“(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, §421, July 1, 1988, 102 Stat. 765–768, as amended by Pub. L. 100–647, title VIII, §814, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–239, title VI, §608(a), Oct. 13, 1990, 104 Stat. 2411, 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 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 the dissent of such information with 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, 1996, 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 organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by this chapter, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

(B) to determine whether payments for services other than those for which payment may...