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42 U.S. Code § 1395w-22

Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w–28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w–24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term "benefits under the original medicare fee-for-service program option" means, subject to subsection (m), those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1395w–27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).

(III) Skilled nursing care.

(IV) Clinical diagnostic laboratory test administered during any portion of the emergency period defined in paragraph (1)(B) of section 1320b–5(g) of this title beginning on or after March 18, 2020, for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 and the

administration of such test.

(V) Specified COVID–19 testing-related services (as described in section 1395*l*(cc)(1) of this title) for which payment would be payable under a specified outpatient payment provision described in section 1395*l*(cc)(2) of this title.

(VI) A COVID–19 vaccine and its administration described in section 1395x(s)(10)(A) of this title.

(VII) A drug or biological product that is a selected drug (as referred to insection 1320f–1(c) of this title).

(VIII) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv), other than subclauses (IV), (V), and (VI) of such clause, for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(vi) Prohibition of application of certain requirements for COVID–19 testing

In the case of a product or service described in subclause (IV) or (V), respectively, of clause (iv) that is administered or furnished during any portion of the emergency period described in such subclause beginning on or after March 18, 2020, an MA plan may not impose any prior authorization or other utilization management requirements with respect to the coverage of such a product or service under such plan.

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) Reference to related provisions

For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) and section 1395cc(a)(1)(O) of this title, and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w–24(e) of this title.

(C) Election of uniform coverage determination

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Subject to subparagraph (D), each Medicare+Choice organization may provide to individuals enrolled

under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w–28(b)(2)(B) of this title. In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title.

(D) Expanding supplemental benefits to meet the needs of chronically ill enrollees

(i) In general

For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1395w–28(b)(6) of this title), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

(ii) Supplemental benefits described

(I) In general

Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

(II) Authority to waive uniformity requirements

The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

(iii) Chronically ill enrollee defined

In this subparagraph, the term "chronically ill enrollee" means an enrollee in an MA plan that the Secretary determines—

(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

(II) has a high risk of hospitalization or other adverse health outcomes; and

(III) requires intensive care coordination.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w–23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1395w–23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w–21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) Special benefit rules for regional plans

In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1395w–27a(b) of this title.

(7) Limitation on cost-sharing for dual eligibles and qualified medicare beneficiaries

In the case of an individual who is a full-benefit dual eligible individual (as defined insection 1396u–5(c)(6) of this title) or a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under subchapter XIX if the individual were not enrolled in such plan.