

SEC. 162. REVISIONS TO REQUIREMENTS FOR MEDICARE ADVANTAGE  
PRIVATE FEE-FOR-SERVICE PLANS.

(a) Requirements To Assure Access to Network Coverage-

(1) INDIVIDUAL MARKET- Section 1852(d) of the Social Security Act (42 U.S.C. 1395w-22(d)) is amended--

(A) in paragraph (4), in the second sentence, by striking ‘The Secretary’ and inserting ‘Subject to paragraph (5), the Secretary’; and

(B) by adding at the end the following new paragraph:

‘(5) REQUIREMENT OF CERTAIN NONEMPLOYER MEDICARE  
ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE  
CONTRACTS WITH PROVIDERS-

‘(A) IN GENERAL- For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1857(i) operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

‘(B) NETWORK AREA DEFINED- For purposes of subparagraph (A), the term ‘network area’ means, for a plan year, an area which the Secretary identifies (in the Secretary’s announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

‘(C) NETWORK-BASED PLAN DEFINED-

‘(i) IN GENERAL- For purposes of subparagraph (B), the term ‘network-based plan’ means--

‘(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1851(a)(2)(A)(i);

‘(II) a network-based MSA plan; and

‘(III) a reasonable cost reimbursement plan under section 1876.

‘(ii) EXCLUSION OF NON-NETWORK REGIONAL PPOS- The term ‘network-based plan’ shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.’.

(2) EMPLOYER PLANS- Section 1852(d) of the Social Security Act ([42 U.S.C. 1395w-22\(d\)](#)), as amended by paragraph (1), is amended--

(A) in paragraph (4), in the second sentence, by striking ‘paragraph (5)’ and inserting ‘paragraphs (5) and (6)’; and

(B) by adding at the end the following new paragraph:

‘(6) REQUIREMENT OF ALL EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS- For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1857(i), the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.’.

(3) ACCESS REQUIREMENTS-

(A) IN GENERAL- Section 1852(d)(4)(B) of the Social Security Act ([42 U.S.C. 1395w-22\(d\)\(4\)\(B\)](#)) is amended by striking ‘a sufficient number’ through ‘terms of the plan’ and inserting ‘a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)’.

(B) EFFECTIVE DATE- The amendment made by subparagraph (A) shall apply to plan year 2010 and subsequent plan years.

(b) Clarification Regarding Utilization- Section 1859(b)(2) of the Social Security Act ([42 U.S.C. 1395w-28\(b\)\(2\)](#)) is amended by adding at the end the following flush sentence:

‘Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.’.