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119TH CONGRESS
2D SESSION

H. R. 9544

To amend title XVIII of the Social Security Act to ensure appropriate payments under Medicare Advantage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 30, 2026

Mr. DOGGETT (for himself, Ms. ANSARI, Ms. BALINT, Mr. CASAR, Ms. CHU, Ms. CLARKE of New York, Mr. CLEAVER, Mr. COHEN, Mr. DAVIS of Illinois, Ms. DELAURO, Mr. DELUZIO, Mrs. DINGELL, Mr. GARAMENDI, Mr. GARCÍA of Illinois, Mr. GARCIA of California, Mrs. GRIJALVA, Mr. HUFFMAN, Mr. JACKSON of Illinois, Ms. JAYAPAL, Mr. JOHNSON of Georgia, Mr. KHANNA, Mr. MFUME, Mr. NADLER, Ms. NORTON, Ms. OCASIO-CORTEZ, Ms. OMAR, Ms. PINGREE, Mr. POCAN, Ms. RANDALL, Ms. SCHAKOWSKY, Mr. SCOTT of Virginia, Mr. SMITH of Washington, Mr. TAKANO, Mr. THANEDAR, Mr. THOMPSON of Mississippi, Ms. TLAIB, Ms. VELÁZQUEZ, Ms. WATERS, Mrs. WATSON COLEMAN, Mr. GREEN of Texas, Mr. CARSON, Mr. MCGOVERN, Ms. TOKUDA, and Mr. DESAULNIER) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to ensure appropriate payments under Medicare Advantage, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Saving Medicare Enrollees from Deceptive Insurers and Creating Ample Resources for Everyone Act of 2026'' or the ''Save MEDICARE Act of 2026''.

SEC. 2. RISK ADJUSTMENT.

(a) RULEMAKING.—As part of the annual rulemaking cycle for Medicare Advantage for payments applicable to 2028 and subsequent years, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services—

(1) shall include an analysis identifying diagnosis codes with a high rate of differential coding between equivalent enrollees in Medicare Advantage and Medicare beneficiaries not enrolled under a Medicare Advantage plan, a high rate of discretionary coding, or limited treatment implications; and

(2) shall exclude or adjust diagnosis codes that the Secretary determines are most likely to be subject to coding variation by Medicare Advantage plans from diagnosis data submitted to the Secretary for purposes of determining appropriate payment adjustments for health status.

(b) EXCLUSION OF DIAGNOSES COLLECTED FROM CHART REVIEWS AND HEALTH RISK ASSESSMENTS.—

(1) MEDICARE ADVANTAGE PLANS.—Section 1853(a)(1)(C) of such Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

"(iv) EXCLUSION OF DIAGNOSES COLLECTED FROM CHART REVIEWS AND HEALTH RISK ASSESSMENTS.—

"(I) IN GENERAL.—For 2028 and each subsequent year, for purposes of establishing the payment adjustment factors and adjusting payment based on health status under clause (i), the Secretary shall not take into account a diagnosis collected from a chart review or a health risk assessment.

"(II) IDENTIFICATION OF DIAGNOSES COLLECTED FROM CHART REVIEWS AND HEALTH RISK ASSESSMENTS.—The Secretary shall establish procedures to provide for the identification and verification of diagnoses collected from chart reviews and health risk assessments.".

(2) PRESCRIPTION DRUG PLANS.—Section 1860D–15(c)(1) of the Social Security Act (42 U.S.C. 1395w–115(c)(1)) is amended by adding at the end the following new subparagraph:

''(E) EXCLUSION OF DIAGNOSES COLLECTED FROM CHART REVIEWS AND HEALTH RISK ASSESSMENTS.—

''(i) IN GENERAL.—For 2028 and each subsequent year, for purposes of establishing the methodology and adjusting the standardized bid amount based on health status under subparagraph (A), the Secretary shall not take into account a diagnosis collected from a chart review or a health risk assessment.

''(ii) IDENTIFICATION OF DIAGNOSES COLLECTED FROM CHART REVIEWS AND HEALTH RISK ASSESSMENTS.—The Secretary shall establish procedures to provide for the identification and verification of diagnoses collected from chart reviews and health risk assessments.''.

(c) MEDPAC STUDY AND REPORT.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study to determine how

results from a Consumer Assessment of Healthcare Providers and Systems (CAPHS)-sized survey could be extrapolated across all enrollees under a Medicare Advantage contract for the purposes of calculating risk adjusted payments. Such study shall include recommendations on methodology, modifications to the CAPHS survey questions, and CAHPS survey sample size.

(2) REPORT.—Not later than 3 years after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

SEC. 3. QUALITY BONUS PROGRAM.

Section 1853(o)(1) of the Social Security Act (42 U.S.C. 1395w–23(o)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''and ending with 2028,'' after ''2012''.

SEC. 4. BENCHMARK PAYMENTS.

(a) ELIMINATING THE COUNTY QUARTILE SYSTEM.—Section 1853(n)(2)(A) of the Social Security Act (42 U.S.C. 1395w–23(n)(2)(A)) is amended—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and indenting appropriately;

(2) by striking ''is the product of'' and inserting ''is—

''(i) for each of 2012 through 2027, the product of''; and

(3) by adding at the end the following new clause:

''(ii) for 2028 and each subsequent year, is the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4) and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5).''.

(b) MODIFICATIONS TO BASE PAYMENT AMOUNT.—Section 1853(n)(2) of the Social Security Act (42 U.S.C. 1395w–23(n)(2)) is amended—

(1) in subparagraph (E), by striking ''subparagraphs (F) and (G)'' and inserting ''subparagraphs (F), (G), and (H)''; and

(2) by adding at the end the following new subparagraph:

''(H) ADJUSTMENT FOR FAVORABLE SELECTION.—For 2028 and each subsequent year:

''(i) IN GENERAL.—The base payment amount specified in subparagraph (E) for a year shall be adjusted to account for favorable selection between Medicare Advantage and the original Medicare fee-for-service program under parts A and B in accordance with this subparagraph.

''(ii) ANALYSIS.—

''(I) IN GENERAL.—In order to ensure the accuracy of the adjustment under clause (i), the Secretary shall annually conduct an analysis of any differences in selection between Medicare Advantage and the original Medicare fee-for-service program under parts A and B described in such subclause and publish the results of such analysis on the internet website of the

Centers for Medicare & Medicaid Services in plain language and in research-downloadable files. The Secretary shall conduct such analysis among subgroups of the Medicare population, including by at a minimum race, gender, zip code, income level, and health condition.

''(II) TIMING.—The Secretary shall complete such analysis by the date necessary to ensure that the results of such analysis are incorporated on a timely basis into the base payment amount for 2029 and subsequent years.

''(III) DATA.—In conducting such analysis, the Secretary shall use data submitted with respect to 2025 and subsequent years, as available and updated as appropriate.

''(iii) METHODOLOGY.—In calculating the adjustment under clause (i) for each year, the Secretary shall apply the Medicare Payment Advisory Commission's method for estimating favorable selection

into Medicare Advantage as described in its March 2026 report to Congress. Applying such method, the Secretary shall calculate a 'selection percentage' to adjust for favorable selection between Medicare Advantage and the original Medicare fee-for-service program under parts A and B. The selection percentage shall be calculated before the intervention of Medicare Advantage plans as the ratio of expected spending for the national average Medicare Advantage beneficiary relative to expected spending for the national average fee-for-service beneficiary, after standardizing for measured risk A value of 1 indicates no difference in expected spending while values below 1 indicate lower expected spending in Medicare Advantage than in fee-for-service Medicare for beneficiaries with the same risk scores. The base payment amount specified in subparagraph (E) shall be multiplied by the selection percentage to yield a selection-adjusted base payment amount. The selection-adjusted base payment amount shall replace the prior

base payment amount in all calculations of payment benchmarks for Medicare Advantage.

''(iv) MEDPAC REVIEW.—The Medicare Payment Advisory Commission shall conduct and publish a review of the analysis conducted under clause (ii) and any adjustments made under clause (i) based on such analysis not later than 2 years after implementation of this subparagraph and biennially thereafter.''.

SEC. 5. RISK ADJUSTMENT DATA VALIDATION.

(a) RISK ADJUSTMENT DATA VALIDATION REFORMS.—Section 1853(a)(1)(C) of the Social Security Act is amended by adding at the end the following new paragraph:

''(7) IMPROVING TIMELINESS OF RADV AUDITS AND APPEALS.—For plan years beginning on or after January 1, 2028, the following requirements shall apply with respect to the Medicare Advantage Risk Adjustment Data Validation Program:

''(A) CONTRACT-LEVEL AUDITS.—The Secretary shall complete contract-level audits within one year.

"(B) MEDICAL RECORD REVIEWS.—The Secretary shall complete RADV medical record reviews within 60 days.

"(C) DEADLINE FOR COMPLETION OF STAGES 1 AND 2 OF APPEALS.—

"(i) STAGE 1.—The reconsideration stage described in section 422.311(c)(6) of title 42, Code of Federal Regulations (or a successor regulation), shall be completed within 90 days.

"(ii) STAGE 2.—The hearing stage described in section 422.311(c)(7) of title 42, Code of Federal Regulations (or a successor regulation), shall be completed within 90 days.

"(D) USER FEE.—The Secretary shall reduce the payments to Medicare Advantage organizations under section 1853 by 0.02 percent for the purpose of carrying out Risk Adjustment Data Validation audits.

"(E) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise of any determination of the Administrator of the Centers for Medi-

care and Medicaid Services under the Risk Adjustment Data Validation audit program.

''(F) AUTHORITY TO EXTRAPOLATE.—The Secretary may extrapolate the results of audited samples to the general Medicare Advantage population and retroactively, as the Secretary determines appropriate.''.

(b) ENHANCING AUDIT PROCESS.—Section 1853(a)(1)(C) of the Social Security Act, as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(8) IDENTIFICATION AND RECOUPMENT OF OVERPAYMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into contracts with one or more recovery audit contractors under section 1893(h) for the identification and recoupment of overpayments, including penalties as defined under subparagraph (B), with respect to items and services for which payment is made under this part.

''(B) PENALTY.—With respect to any overpayment identified under subparagraph (A), the Secretary shall provide for the imposition a penalty in an amount equal to the total amount of overpayment and the rate of interest as de-

fined under section 405.378(d) of title 42, Code of Federal Regulations (or a successor regulation).

''(C) CONTINGENCY FEES.—The Secretary may provide contingency fees to recovery audit contractors in an amount equal to no more than 20 percent of recouped overpayments made by such contractor.''.

SEC. 6. GUARD VETERANS HEALTH CARE ACT.

(a) COST-RECOVERY FROM MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG PLANS.—

(1) COST RECOVERY.—

(A) IN GENERAL.—Subchapter III of chapter 17 of title 38, United States Code, is amended by inserting after section 1729B the following new section:

''§ 1729C. Cost-recovery from Medicare Advantage and Medicare prescription drug plans

''(a) IN GENERAL.—Notwithstanding sections 1814(c), 1835(d), and 1862(a)(3) of the Social Security Act (42 U.S.C. 1395f(c), 1395n(d), and 1395y(a)(3)), if the Secretary provides under this chapter any health care item or service (including for a service-connected disability or a non-service-connected disability) covered under the Medicare program under title XVIII of the Social Security

Act (42 U.S.C. 1395 et seq.), including outpatient and inpatient care, prescription drugs, medical devices, lab testing, and items or services delivered in post-acute and long-term care settings, to any individual who is enrolled in a Medicare Advantage plan, including an MA–PD plan, offered by a MA organization under part C of such title or a prescription drug plan offered by a PDP sponsor under part D of such title, such organization or sponsor shall, to the extent such item or service is covered under such Medicare Advantage plan or prescription drug plan, reimburse the Secretary for such item or service regardless of any additional documentation, utilization management, or other administrative requirement the plan may impose on the item or service.

''(b) RECOVERY OF AMOUNTS.—

''(1) IN GENERAL.—The Secretary shall recover amounts required to be reimbursed under subsection (a) through the use of procedures under section 1729 of this title to the same extent as those procedures are used to recover amounts authorized to be recovered under that section.

''(2) AMOUNT AND PROCESS.—Except as provided in paragraph (1), recovery under that paragraph of amounts reimbursed under subsection (a) shall be in such an amount, and occur in accordance

with such procedures, as the Secretary shall prescribe for purposes of this section.

''(c) APPLICATION.—The provisions of subsection (a) shall apply to Medicare Advantage and prescription drug plan years beginning on or after January 1, 2028.

''(d) TREATMENT OF AMOUNTS.—Amounts reimbursed to the Secretary under subsection (a) shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund under section 1729A of this title.''.

(B) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729B the following new item:

''1729C. Cost-recovery from Medicare Advantage and Medicare prescription drug plans.''.

(2) MEDICARE CONFORMING AMENDMENTS.—

(A) PART A.—Section 1814(c) of the Social Security Act (42 U.S.C. 1395f(c)) is amended by inserting ''and section 1729C of title 38, United States Code'' after ''section 1880''.

(B) PART B.—Section 1835(d) of the Social Security Act (42 U.S.C. 1395n(d)) is amended by inserting ''and section 1729C of title 38, United States Code'' after ''section 1880''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a)(3) of the Social Security Act (42 U.S.C. 1395y(a)(3)) is amended by inserting ''in the case of items and services and prescription drugs for which reimbursement is made under section 1729C of title 38, United States Code,'' after ''section 1880(e),''.

(b) MODIFICATION OF AUTHORITY FOR RECOVERY BY UNITED STATES OF REASONABLE CHARGES FOR CERTAIN CARE OR SERVICES FURNISHED TO VETERANS FOR NON-SERVICE-CONNECTED DISABILITIES.—Section 1729 of title 38, United States Code, is amended—

(1) in subsection (a)—

(A) by amending paragraph (1) to read as follows:

''(1)(A) Subject to the provisions of this section, the United States has the right to recover or collect the reasonable charges for care or services that the United States is required by law to furnish or pay for under this chapter for a non-service-connected disability.

''(B) The United States has the right to recover or collect from a third party the reasonable charges for care or services furnished as described in subparagraph (A) to the extent that the recipient or provider of the care or

services would be eligible to receive payment from a third party.

''(C) The right to recover or collect reasonable charges for care or services under this section shall apply to any and all causes of action or recovery rights in tort or under any policy, plan, or contract providing benefits for health care or injury, which accrue to the individual to whom the care or services were furnished, or to the legal representatives of the individual, as a result of the non-service-connected disability that necessitated the care or services.''; and

(B) in paragraph (2)—

(i) in subparagraph (D), by striking ''; or'' and inserting a semicolon;

(ii) in subparagraph (E)(2), by striking the period at the end and inserting ''; or''; and

(iii) by adding at the end the following new subparagraph:

''(F) that is incurred by an individual who is entitled to care (or payment of expenses of care) under circumstances creating a tort liability upon a third party.'';

(2) in subsection (b), by amending paragraph (2) to read as follows:

''(2)(A) The United States may take any action necessary to enforce the subrogation interests of the United States under this section, including by intervening or joining in an action or proceeding.

''(B) A proceeding under this section may not be brought after the end of the six-year period beginning on the last day on which the care or services for which recovery is sought are furnished. Notwithstanding the previous sentence, subject to section 2415 of title 28, and except as otherwise provided by law, any action for money damages under this section brought by the United States or an officer or agency thereof that is founded upon a tort shall be barred unless the complaint is filed within three years after the right of action first accrues.'';

(3) in subsection (c)(1), by inserting ''or penalty'' after ''claim'';

(4) by redesignating subsections (h) and (i) as subsections (l) and (m), respectively;

(5) by inserting after subsection (f) the following new subsections:

''(g)(1) Not later than 45 days after receipt of a claim to recover or collect the reasonable charges for care or services described in subsection (a), or in the case of a tort, not later than 45 days after settlement, judgment,

award, liability determination, or resolution relating to the cause of action, a third party shall—

"(A) pay a clean claim for reimbursement in accordance with this section;

"(B) pay the amount agreed to in writing by the Department; or

"(C) provide notice of the date the third party received the claim and include a statement that—

"(i) the third party refuses to reimburse all or part of the claim and specify each reason for the refusal to pay; or

"(ii) additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary.

"(2) Paragraph (1) shall not apply to a claim if there is a good faith dispute about the legitimacy of the claim.

"(3)(A) If any third party fails to comply with paragraph (1), such third party shall be required to pay interest to the United States at the rate established by the Secretary of the Treasury under section 3717 of title 31 per month on the amount of the claim that remains unpaid at the end of the 45-day period specified in such paragraph.

''(B) The interest paid pursuant to subparagraph (A) shall be included in any late reimbursement from a third party without requiring the Secretary to make any additional claim for such interest.

''(4)(A) Upon receiving a request for additional information by a third party pursuant to paragraph (1)(C)(ii), the Secretary shall provide the additional information, if determined relevant by the Secretary, not later than 45 days after receipt of the request for additional information.

''(B) Failure to furnish relevant information within the time required under subparagraph (A) shall not invalidate or reduce any claim in connection with such information.

''(C)(i) Not later than 15 days after receipt of additional relevant information under subparagraph (A), a third party shall pay a clean claim in accordance with this subsection or send a written or electronic notice that—

''(I) such third party refuses to reimburse all or part of the claim; and

''(II) specifies each reason for refusal to pay.

''(ii) Any third party that fails to comply with clause (i) shall pay interest to the United States on any amount of the claim that remains unpaid at the rate established

by the Secretary of the Treasury under section 3717 of title 31.

''(5) A third party shall not be entitled to request a refund to correct a payment error to the Department if the request by the third party for such payment correction is submitted more than 18 months after the date that the Department received payment from the third party.

''(6) Any claim by the Department under this section shall not be subject to non-Department claims processes, policies, or forms.

''(h) The recovery rights of the United States under this section are not limited to the amounts paid to non-Department providers and are not subject to non-Department fee schedules or non-Department reimbursement rates, including those administered under workers' compensation plans or automobile accident reparations insurance.

''(i)(1) A third party shall—

''(A) determine whether a recipient of care or services covered by this section (including a recipient whose claim is unresolved) has received benefits under this chapter; and

''(B) submit the information described in paragraph (2) with respect to the recipient to the Sec-

retary in a form and manner (including frequency) specified by the Secretary.

''(2) The information required to be submitted under this paragraph with respect to a recipient of care or services is—

''(A) the identity of the recipient; and

''(B) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

''(3) A third party shall submit the information required under paragraph (1)(B) with respect to a recipient of care or services covered by this section (including a recipient whose claim is unresolved) not later than 30 days, or such other time period as prescribed by the Secretary, after the date on which the third party knows or has reason to know that the recipient has received benefits under this chapter.

''(4) A third party shall not distribute proceeds of a settlement, judgment, award, or other payment in connection with a recipient of care or services covered by this section (including a recipient whose claim is unresolved), regardless of whether there has been a determination or

admission of liability, without satisfaction of a claim by the Department.

''(j)(1) A third party that fails to comply with the requirements under this section, including any regulations prescribed to implement this section, with respect to any individual receiving care furnished or paid for by the Department as described in this section, shall be subject to a civil penalty in an amount published on a website of the Department for each day of noncompliance with respect to each claim violation. A civil penalty under this paragraph shall be in addition to any other penalties prescribed by law.

''(2)(A) A third party that willfully fails or refuses to pay a clean claim under this section, including any regulations prescribed to implement this section, with respect to any individual receiving care furnished or paid for by the Department as described in this section, shall be subject to paying the higher of triple the amount of the claim or an amount not to exceed $50,000, which may be adjusted for inflation, for each claim violation.

''(B) A penalty under subparagraph (A) is in addition to any other penalty under this subsection and any other penalty prescribed by law.

''(C) Before enforcing any penalty under this paragraph with respect to a third party, the Secretary shall

provide to the third party written notice of the amount due and a 30-day opportunity to pay the clean claim, including penalties, interests, and costs.

''(3) Notwithstanding any other applicable civil or criminal remedies, the United States shall have a cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a third party that fails to provide payment, or appropriate reimbursement, for the reasonable value of the care or services furnished, to be furnished, paid for, or to be paid for in accordance with a clean claim.

''(k) Notwithstanding any other provision of law, the Secretary may implement this paragraph by prescribing regulations, program instructions, or otherwise.''; and

(6) in subsection (m), as redesignated by paragraph (4)—

(A) in paragraph (3)—

(i) in subparagraph (C), by striking ''; or'' and inserting a semicolon;

(ii) in subparagraph (D), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new subparagraphs:

''(E) a person or entity responsible in tort for damages incurred as a result of negligence; or

''(F) a person or entity responsible for payment of medical expenses other than under a health-plan contract, including medical expenses coverage, medical payments coverage, or underinsured motorist coverage.''; and

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

''(4) The term 'clean claim' means a claim to recover or collect reasonable charges under subsection (a) that can be processed without obtaining additional information.

''(5) The term 'non-service-connected disability' includes—

''(A) a non-service-connected disability, injury, illness, health care need, or condition; and

''(B) an aggravation or exacerbation of a service-connected disability.''.

(c) CONFORMING AMENDMENT.—Section 1853(c)(1)(D)(iii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(D)(iii)) is amended by inserting ''(before 2028)'' after ''for a year''.

SEC. 7. ALLOWING STATES TO ENFORCE MEDICARE ADVANTAGE PLAN REQUIREMENTS.

Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended—

(1) by striking ''The standards'' and inserting the following:

''(A) IN GENERAL.—Subject to subparagraph (B), the standards''; and

(2) by adding at the end the following new subparagraphs:

''(B) STATE ENFORCEMENT.—Each State may require that MA organizations that issue, sell, renew, or offer MA plans in the State meet the requirements of this part with respect to such MA plans.

''(C) COORDINATION OF ENFORCEMENT.—The Secretary shall coordinate enforcement of the standards established under this part with the State in which an MA organization is licensed and any State in which the MA organization issues, sells, renews, or offers MA plans. The Secretary may enter into a collaborative enforcement agreement with any State to further coordinate enforcement.''.

SEC. 8. PROVIDER INCENTIVE CONTRACTS.

Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(7) PROHIBITING PERCENTAGE OF PREMIUM CONTRACTS OR OTHER FINANCIAL INCENTIVES FOR CODING.—Beginning with plan years beginning on or after January 1, 2028, a contract under this section with an MA organization shall prohibit the use of percentage of premium contracts or other financial incentives for providers related to coding items and services furnished to enrollees under this part.''.

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