

COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COV-
ERAGE FOR KIDNEY TRANSPLANT PATIENTS ACT OF
2020

DECEMBER 24, 2020.—Committed to the Committee of the Whole House on the State
of the Union and ordered to be printed

Mr. PALLONE, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

[To accompany H.R. 5534]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5534) to amend title XVIII of the Social Security Act to provide for extended months of Medicare coverage of immunosuppressive drugs for kidney transplant patients, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020”.

SEC. 2. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVISIONS.

(a) **MEDICARE ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT RECIPIENTS.**—

(1) **IN GENERAL.**—Section 226A(b)(2) of the Social Security Act (42 U.S.C. 426–1(b)(2)) is amended by inserting “(except for eligibility for enrollment under part B solely for purposes of coverage of immunosuppressive drugs described in section 1861(s)(2)(J))” before “, with the thirty-sixth month”.

(2) **INDIVIDUALS ELIGIBLE ONLY FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.**—

(A) **IN GENERAL.**—Section 1836 of the Social Security Act (42 U.S.C. 1395o) is amended—

(i) by striking “Every” and inserting “(a) **IN GENERAL.**—EVERY”; and

(ii) by adding at the end the following new subsection:

“(b) **INDIVIDUALS ELIGIBLE FOR IMMUNOSUPPRESSIVE DRUG COVERAGE.**—

“(1) **IN GENERAL.**—Except as provided under paragraph (2), every individual whose entitlement to insurance benefits under part A ends (whether before, on, or after January 1, 2023) by reason of section 226A(b)(2) is eligible to enroll or to be deemed to have enrolled in the medical insurance program established by this part solely for purposes of coverage of immunosuppressive drugs in accordance with section 1837(m).

“(2) **EXCEPTION IF OTHER COVERAGE IS AVAILABLE.**—

“(A) **IN GENERAL.**—An individual described in paragraph (1) shall not be eligible for enrollment in the program for purposes of coverage described in such paragraph with respect to any period in which the individual, as determined in accordance with subparagraph (B)—

“(i) is enrolled in a group health plan or group or individual health insurance coverage, as such terms are defined in section 2791 of the Public Health Service Act;

“(ii) is enrolled for coverage under the TRICARE for Life program under section 1086(d) of title 10, United States Code;

“(iii) is enrolled under a State plan (or waiver of such plan) under title XIX;

“(iv) is enrolled under a State child health plan under title XXI; or

“(v) (I) is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code;

“(II) is not required to enroll under section 1705 of such title to receive immunosuppressive drugs described in this subsection; or

“(III) is otherwise eligible under a provision of title 38, United States Code, other than section 1710 of such title to receive immunosuppressive drugs described in this subsection.

“(B) **ELIGIBILITY DETERMINATIONS.**—

“(i) **IN GENERAL.**—The Secretary, in coordination with the Commissioner of Social Security, shall establish a process for determining whether an individual described in paragraph (1) who is to be enrolled or deemed to be enrolled in the medical insurance program described in such paragraph meets the requirements for such enrollment under this subsection, including the requirement that the individual not be enrolled in other coverage as described in subparagraph (A).

“(ii) **ATTESTATION REGARDING OTHER COVERAGE.**—The process established under clause (i) shall include, at a minimum, a requirement that—

“(I) the individual provide to the Commissioner an attestation that the individual is not enrolled and does not expect to enroll in such other coverage; and

“(II) the individual agree to notify the Commissioner within 60 days of enrollment in such other coverage.”.

(B) **CONFORMING AMENDMENT.**—

(i) **IN GENERAL.**—Sections 1837, 1838, and 1839 of the Social Security Act (42 U.S.C. 1395p, 42 U.S.C. 1395q, 42 U.S.C. 1395r) are each

amended by striking “1836” and inserting “1836(a)” each place it appears.

(ii) ADDITIONAL AMENDMENT.—Section 1837(j)(1) of such Act (42 U.S.C. 1395p(j)(1)) is amended by striking “1836(1)” and inserting “1836(a)(1)”.

(b) ENROLLMENT FOR INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

“(m)(1) Any individual who is eligible for coverage of immunosuppressive drugs under section 1836(b) may enroll or be deemed to have enrolled only in such manner and form as may be prescribed by regulations, and only during an enrollment period described in this subsection.

“(2) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 226A(b)(2) prior to January 1, 2023, may enroll beginning on October 1, 2022, or the day on which the individual first satisfies section 1836(b), whichever is later.

“(3) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 226A(b)(2) on or after January 1, 2023, shall be deemed to have enrolled in the medical insurance program established by this part for purposes of coverage of immunosuppressive drugs.

“(4) The Secretary shall establish a process under which an individual described in paragraph (1) whose other coverage described in section 1836(b)(2)(A), or coverage under this part (including the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs) is terminated voluntarily or involuntarily may enroll or reenroll, if applicable, in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.”

(c) COVERAGE PERIOD FOR INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1838 of the Social Security Act (42 U.S.C. 1395q) is amended by adding at the end the following new subsection:

“(g) In the case of an individual described in section 1836(b)(1), the following rules shall apply:

“(1) In the case of such an individual who is deemed to have enrolled in part B for coverage of immunosuppressive drugs under section 1837(m)(3), such individual’s coverage period shall begin on the first day of the month in which the individual first satisfies section 1836(b).

“(2) In the case of such an individual who enrolls (or reenrolls, if applicable) in part B for coverage of immunosuppressive drugs under paragraph (2) or (4) of section 1837(m), such individual’s coverage period shall begin on January 1, 2023, or the month following the month in which the individual so enrolls (or reenrolls), whichever is later.

“(3) The provisions of subsections (b) and (d) shall apply with respect to an individual described in paragraph (1) or (2).

“(4) In addition to the reasons for termination under subsection (b), the coverage period of an individual described in paragraph (1) or (2) shall end when the individual becomes entitled to benefits under this title under section 226(a) or 226A or is no longer eligible for such coverage as a result of the application of section 1836(b)(2).

“(5) The Secretary may conduct public education activities to raise awareness of the availability of more comprehensive, qualified health plans for individuals eligible under section 1836(b) to enroll or to be deemed enrolled in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.”

(2) CONFORMING AMENDMENTS.—Section 1838(b) of the Social Security Act (42 U.S.C. 1395q(b)) is amended, in the matter following paragraph (2), by inserting “or section 1837(m)(3)” after “section 1837(f)” each place it appears.

(d) PREMIUMS FOR INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (b), by adding at the end the following new sentence: “No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1836(b) for coverage only of immunosuppressive drugs.”; and

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

“(j) DETERMINATION OF PREMIUM FOR INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—The Secretary shall, during September of each year (beginning with 2022), determine and promulgate a monthly premium rate for the succeeding calendar year for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1836(b). Such premium shall be

equal to 35 percent of the monthly actuarial rate for enrollees age 65 and over (as would be determined in accordance with subsection (a)(1) if the reference to ‘one-half’ in such subsection were a reference to ‘100 percent’) for that succeeding calendar year. The monthly premium of each individual enrolled for coverage of immunosuppressive drugs under section 1836(b) for each month shall be the amount promulgated in this subsection. Such amount shall be adjusted in accordance with subsections (c), (f), and (i), but shall not be adjusted under subsection (b).”

(e) ENSURING COVERAGE UNDER THE MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(A) of the Social Security Act (42 U.S.C. 1396d(p)(1)(A)) is amended by inserting “or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1836(b)” after “under section 1818A”.

(f) PART D.—Section 1860D–1(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–101(a)(3)(A)) is amended by inserting “(but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1836(b))” before the period at the end.

SEC. 3. GAO STUDY AND REPORT.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the implementation of coverage of immunosuppressive drugs for kidney transplant patients under the Medicare program pursuant to the provisions of, and amendments made by, this Act.

(b) REPORT.—Not later than January 1, 2025, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations as the Comptroller General determines appropriate.

I. PURPOSE AND SUMMARY

H.R. 5534, the “Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2019”, introduced by Representatives Ron Kind (D–WI) and Michael Burgess (R–TX), would permanently remove the 36-month limit for Medicare coverage of immunosuppressive drugs following a kidney transplant.

II. BACKGROUND AND NEED FOR LEGISLATION

Kidney transplant patients must take immunosuppressive drugs for the life of their transplant to reduce the risk of organ rejection. The Medicare End Stage Renal Disease (ESRD) program was established by Congress in 1972 to cover individuals with ESRD, including those under the age of 65. Since its inception in 1972, the Medicare ESRD program has covered dialysis and kidney transplantation regardless of a beneficiary’s age. If a Medicare beneficiary who receives a kidney transplant is only eligible for Medicare coverage due to ESRD status and not age, however, Medicare will not cover immunosuppressive drugs for that kidney transplant patient for more than 36 months following the transplant procedure.¹ Without Medicare coverage, the costs of these drugs may be prohibitive for some individuals, thereby increasing the risk of non-compliance and organ rejection. Organ rejection could result in the development of ESRD and require dialysis, which could potentially lead to a subsequent transplant. In the case of organ rejection, Medicare would once again pay for dialysis, a second transplant, and another 36 months of immunosuppressive drugs.

Studies conducted in 2019 by the Department of Health and Human Services (HHS) found that extending Medicare coverage of immunosuppressive drugs for the life of the transplant would result in savings to the Medicare program by decreasing the in-

¹Centers for Medicare and Medicaid Services, Kidney Transplants (www.medicare.gov/coverage/kidney-transplants).

stances of costly dialysis treatments.² A patient on dialysis costs the Medicare program almost \$86,000 per year, while immunotherapy under part B costs approximately \$2,300 per year.³ One HHS analysis found that 375 kidney transplant failures in 2015 alone were preventable had immunosuppressive drug coverage been extended.⁴ That same HHS analysis included data showing that the per person per year average cost of reversion to dialysis is \$116,902 for the first year and \$91,306 in the later years, compared with \$3,379 per person per year average for immunosuppressive drugs.

H.R. 5534 would permanently remove the 36-month limit for Medicare coverage of immunosuppressive drugs following a kidney transplant for those who have no other form of health insurance coverage. This bill would establish a new Medicare part B benefit to cover immunosuppressive drugs past 36 months for this specific population. This coverage of last resort will help reduce the likelihood of graft loss and the demand for additional transplants, ultimately improving patients' health and reducing costs to the Medicare program.

III. COMMITTEE HEARINGS

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearing was used to develop or consider H.R. 5534:

On January 8, 2020, the Subcommittee on Health held a hearing entitled "Legislation to Improve Americans' Health Care Coverage and Outcomes" to consider H.R. 5534. The Subcommittee received testimony from the following witnesses:

- Lee Beers, M.D., President-Elect, American Academy of Pediatrics
- Kenneth Mendez, President and Chief Executive Officer, Asthma and Allergy Foundation of America
- Stephanie Zarecky, Mother of Scarlett Pauley, Ambassador Program and Public Relations Manager, SUDC Foundation
- Matthew Cooper, M.D., Director, Kidney and Pancreas Transplantation, Medical Director, QAPI, Medstar Georgetown Transplant Institute, Professor of Surgery, Georgetown University School of Medicine
- Kevin Koser, Patient Advocate, On behalf of the National Foundation for Ectodermal Dysplasias
- Fred Riccardi, President, Medicare Rights Center.

²Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Assessing The Costs And Benefits Of Extending Coverage Of Immunosuppressive Drugs Under Medicare* (May 10, 2019) ([aspe.hhs.gov/system/files/pdf/261746/Savings From Extending Coverage For Immunosuppressive Drugs Final.pdf](https://aspe.hhs.gov/system/files/pdf/261746/Savings%20From%20Extending%20Coverage%20For%20Immunosuppressive%20Drugs%20Final.pdf)); Department of Health and Human Services, Office of the Actuary, *Proposal to Extend Coverage of Immunosuppressive Drugs* (May 22, 2019) (www.documentcloud.org/documents/6193012-OACT-Estimate-Extension-ofImmunosuppressive.html).

³House Committee on Energy and Commerce, Testimony of Matthew Cooper, M.D., Director, Kidney and Pancreas Transplantation, Medical Director, QAPI, Medstar Georgetown Transplant Institute, Professor of Surgery, Georgetown University School of Medicine, *Hearing on Legislation to Improve Americans' Health Care Coverage and Outcomes*, 116th Congress (Jan. 8, 2020) (energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Cooper-CoverageandOutcomes_182020.pdf).

⁴Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Assessing The Costs And Benefits Of Extending Coverage Of Immunosuppressive Drugs Under Medicare* (May 10, 2019) (<https://aspe.hhs.gov/pdf-report/assessing-costs-and-benefits-extending-coverage-immunosuppressive-drugs-under-medicare>).

IV. COMMITTEE CONSIDERATION

Representatives Kind and Burgess introduced H.R. 5534 on December 23, 2019, and the bill was referred to the Committee on Energy and Commerce. H.R. 5534 was then referred to the Subcommittee on Health on December 24, 2019. A legislative hearing was held on the bill on January 8, 2020.

On March 11, 2020, the Subcommittee on Health met in open markup session, pursuant to notice, to consider H.R. 5534 and 12 other bills. During consideration of the bill, an amendment in the nature of a substitute offered by Mr. Burgess was agreed to by a voice vote. Subsequently, the Subcommittee on Health agreed by a voice vote to a motion by Ms. Eshoo, Chairwoman of the subcommittee, to forward favorably H.R. 5534, amended, to the full Committee on Energy and Commerce.

On July 15, 2020, the Committee on Energy and Commerce met in virtual open markup session, pursuant to notice, to consider a committee print of the bill H.R. 5534, as amended by the Subcommittee on Health on March 11, 2020. During consideration of the bill, an amendment in the nature of a substitute offered by Mr. Burgess was agreed to by a voice vote. Upon conclusion of consideration of the bill, the full Committee agreed to a motion on final passage by Mr. Pallone, Chairman of the committee, to order H.R. 5534 reported favorably to the House, amended, by a voice vote, a quorum being present.

V. COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee advises that there were no record votes taken on H.R. 5534, including the motion for final passage of the bill.

VI. OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

VII. NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

VIII. CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 2, 2020.

Hon. FRANK PALLONE,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5534, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lara Robillard.

Sincerely,

PHILLIP L. SWAGEL,
Director.

Enclosure.

At a Glance			
H.R. 5534, Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020			
As ordered reported by the House Committee on Energy and Commerce on July 15, 2020			
By Fiscal Year, Millions of Dollars	2021	2021-2025	2021-2030
Direct Spending (Outlays)	0	-10	-400
Revenues	0	0	0
Increase or Decrease (-) in the Deficit	0	-10	-400
Spending Subject to Appropriation (Outlays)	0	0	0
Statutory pay-as-you-go procedures apply?	Yes	Mandate Effects	
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2031?	No	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

The bill would

- Create an additional Medicare benefit option, coverage of the cost of immunosuppressive drugs, for kidney transplant patients who have no other health insurance or drug coverage
- Charge beneficiaries a premium for the new drug-only benefit

Estimated budgetary effects would primarily stem from

- Premiums paid by beneficiaries who enroll in the new drug-only coverage
- New spending for prescription drugs for beneficiaries who enroll
- Reduced spending on other Medicare services

Areas of significant uncertainty include

- The number of beneficiaries who would enroll in the new benefit

Bill summary: H.R. 5334 would create a new, limited benefit under Medicare that would cover a portion of the cost of immuno-

suppressives drugs for people who have had a kidney transplant but whose post-transplant coverage under Medicare has ended. To be eligible, a beneficiary would need to have no other source of health insurance or drug coverage. Enrollees would pay a premium for the coverage.

Estimated Federal cost: The estimated budgetary effect of H.R. 5534 is shown in Table 1. The costs of the legislation fall within budget function 570 (Medicare).

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 5534

	By fiscal year, millions of dollars—											
	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2021– 2025	2021– 2030
	Increases or Decreases (–) in Direct Spending											
Estimated Budget Authority ..	0	0	10	0	–20	–40	–50	–80	–100	–120	–10	–400
Estimated Outlays	0	0	10	0	–20	–40	–50	–80	–100	–120	–10	–400

Basis of estimate: Since 1973, a diagnosis of end-stage renal disease (ESRD) has conferred Medicare eligibility on people who do not otherwise meet the program’s age or disability requirements. Patients with ESRD, a condition in which the kidneys stop functioning, typically require a kidney transplant or lifelong dialysis treatments. Transplant patients’ entitlement to Medicare benefits end 36 months after a successful kidney transplant, unless they have otherwise become eligible for the program. Most patients with successful kidney transplants must take immunosuppressive drugs for the rest of their lives to prevent graft failure—rejection of the transplanted organ. If a person with a transplanted kidney experiences graft failure and must return to dialysis, he or she would again become eligible for Medicare.

H.R. 5534 would add a new Medicare coverage option solely to cover immunosuppressive drugs used by kidney transplant patients. Beneficiaries could enroll beginning 36 months after a transplant if they had no other source of health insurance. Enrollees in the new coverage, which would be available January 1, 2023, would pay a monthly premium equivalent to 35 percent of the actuarial value of the standard Part B benefit.¹ CBO estimates that the monthly premium for the new coverage option would be about \$243 in 2023 and that it would rise to about \$345 in 2030.

CBO analyzed data from many sources and consulted experts, including those from organizations that advocate for people with kidney disease. CBO also reviewed analyses prepared by the Department of Health and Human Services. Those analyses included budgetary estimates of policies to extend coverage of immunosuppressive drugs rather than H.R. 5534 or other specific legislation.²

Using data from the United States Renal Data System, CBO estimates that about 12,000 people would enroll in the new benefit,

¹Beneficiaries who enroll in Medicare Part B, which covers physician care and other out-patient services, pay a monthly premium equal to 25 percent of the expected, or actuarial, value of the benefit. Higher-income people pay a surcharge.

²Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Assessing the Costs and Benefits of Extending Coverage of Immunosuppressive Drugs Under Medicare*, ASPE Issue Brief (May 2019), <https://go.usa.gov/x7xNj>, and Centers for Medicare & Medicaid Services, Office of the Actuary, *Proposal to Extend Coverage of Immunosuppressive Drugs* (May 2019), <https://tinyurl.com/y5j3b6ee> (PDF, 272 KB).

which would include current and future immunosuppressive drugs covered under Part B. Using information on typical drug regimens for kidney transplant patients, CBO estimates that the annual cost of the drug benefit would be about \$3,100 per patient in 2023 and that it would rise to about \$4,000 in 2030. That growth reflects CBO's projections of growth in drug prices.

Maintaining a healthy transplanted kidney can help prevent graft failure and recurrence of ESRD and dialysis. It also prevents renewed eligibility for full benefits under Medicare for patients who do not meet the program's other eligibility requirements. Using its March 2020 baseline, CBO estimates that in 2023, the average annual cost for an ESRD beneficiary under current law will be about \$117,000 and that the cost will rise to about \$150,000 in 2030.³

After analyzing data on the frequency and causes of graft failure, CBO expects that the new drug benefit would prevent graft failure in a relatively small number of enrollees. CBO projects that by 2030, there would be about 1,100 people in the new drug-only coverage option who under current law would be entitled to full Medicare benefits because of a graft failure in a prior year.

CBO's estimate for H.R. 5534 includes premiums that would be paid by beneficiaries, new federal spending on prescription drugs, and averted spending on a full range of Medicare benefits for some kidney transplant patients. CBO expects that the savings from averted dialysis and full Medicare eligibility start to accrue after the spending on the new drug benefit begins. CBO estimates that H.R. 5534 would increase direct spending by \$10 million in 2023, but in subsequent years, savings would accumulate as more enrollees avoid graft failures. In 2030, that effect would be a reduction in direct spending of \$120 million. Over the 2021–2030 period, CBO estimates, H.R. 5534 would reduce direct spending by \$400 million.

Uncertainty: This estimate is subject to considerable uncertainty. In particular, it is unclear how many people would choose to enroll. H.R. 5534 would provide coverage for certain immunosuppressive drugs, but transplant patients require a range of health care services.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in Table 1.

Increase in long-term deficits: none.

Mandates: none.

Estimate prepared by: Federal costs: Lara Robillard; Mandates: Andrew Laughlin.

Estimate reviewed by: Paul Masi, Chief, Health Systems and Medicare Cost Estimates Unit; Leo Lex, Deputy Director of Budget Analysis; Mark Hadley, Chief Operating Officer.

³ Estimated spending reflects more than the cost of dialysis and care specific to an ESRD diagnosis. Many people with ESRD have comorbid conditions, such as diabetes and hypertension.

IX. FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

X. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to remove certain limitations on Medicare coverage of immunosuppressive drugs following a kidney transplant.

XI. DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 5534 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111-139 or the most recent Catalog of Federal Domestic Assistance.

XII. COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

XIII. EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 5534 contains no earmarks, limited tax benefits, or limited tariff benefits.

XIV. ADVISORY COMMITTEE STATEMENT

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

XV. APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

XVI. SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 designates that the short title may be cited as the “Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2019”.

Sec. 2. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions

Section 2 removes the 36-month limit for Medicare coverage of immunosuppressive drugs following a kidney transplant. This sec-

tion establishes a new Medicare part B benefit to cover immunosuppressive drugs past 36 months following a kidney transplant in addition to an enrollment process, eligibility requirements, and premiums for this new part B benefit.

Sec. 3. GAO study and report

Section 3 requires the Government Accountability Office (GAO) to conduct a study on the implementation of coverage of immunosuppressive drugs for kidney transplant patients under the Medicare program pursuant to changes made by H.R. 5534 and submit such report to Congress by January 1, 2025.

XVII. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * *

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

SEC. 226A. (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included within the meaning of the term “employment” for purposes of this title, and (ii) his medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term “employment” for purposes of this title;

(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974, or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term “employment” for purposes of this title; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section; shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under

part B of title XVIII, subject to the deductible, premium, and coinsurance provisions of that title.

(b) Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of title XVIII by reasons of this section on the basis of end stage renal disease—

(1) shall begin with—

(A) the third month after the month in which a regular course of renal dialysis is initiated, or

(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1861(e) (and such additional requirements as the Secretary may prescribe under section 1881(b) for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

(2) shall end, in the case of an individual who receives a kidney transplant (*except for eligibility for enrollment under part B solely for purposes of coverage of immunosuppressive drugs described in section 1861(s)(2)(J)*), with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

(c) Notwithstanding the provisions of subsection (b)—

(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1881(b), entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is initiated;

(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2)) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such course is initiated or resumed; and

(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is resumed.

* * * * *

**TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND
DISABLED**

* * * * *

**PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE
AGED AND DISABLED**

* * * * *

ELIGIBLE INDIVIDUALS

SEC. 1836. **[Every]** (a) *IN GENERAL.*—Every individual who—

(1) is entitled to hospital insurance benefits under part A, or
(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, is eligible to enroll in the insurance program established by this part.

(b) *INDIVIDUALS ELIGIBLE FOR IMMUNOSUPPRESSIVE DRUG COVERAGE.*—

(1) *IN GENERAL.*—Except as provided under paragraph (2), every individual whose entitlement to insurance benefits under part A ends (whether before, on, or after January 1, 2023) by reason of section 226A(b)(2) is eligible to enroll or to be deemed to have enrolled in the medical insurance program established by this part solely for purposes of coverage of immunosuppressive drugs in accordance with section 1837(m).

(2) *EXCEPTION IF OTHER COVERAGE IS AVAILABLE.*—

(A) *IN GENERAL.*—An individual described in paragraph (1) shall not be eligible for enrollment in the program for purposes of coverage described in such paragraph with respect to any period in which the individual, as determined in accordance with subparagraph (B)—

(i) is enrolled in a group health plan or group or individual health insurance coverage, as such terms are defined in section 2791 of the Public Health Service Act;

(ii) is enrolled for coverage under the TRICARE for Life program under section 1086(d) of title 10, United States Code;

(iii) is enrolled under a State plan (or waiver of such plan) under title XIX;

(iv) is enrolled under a State child health plan under title XXI; or

(v)(I) is enrolled in the patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code;

(II) is not required to enroll under section 1705 of such title to receive immunosuppressive drugs described in this subsection; or

(III) is otherwise eligible under a provision of title 38, United States Code, other than section 1710 of such

title to receive immunosuppressive drugs described in this subsection.

(B) ELIGIBILITY DETERMINATIONS.—

(i) IN GENERAL.—The Secretary, in coordination with the Commissioner of Social Security, shall establish a process for determining whether an individual described in paragraph (1) who is to be enrolled or deemed to be enrolled in the medical insurance program described in such paragraph meets the requirements for such enrollment under this subsection, including the requirement that the individual not be enrolled in other coverage as described in subparagraph (A).

(ii) ATTESTATION REGARDING OTHER COVERAGE.—The process established under clause (i) shall include, at a minimum, a requirement that—

(I) the individual provide to the Commissioner an attestation that the individual is not enrolled and does not expect to enroll in such other coverage; and

(II) the individual agree to notify the Commissioner within 60 days of enrollment in such other coverage.

ENROLLMENT PERIODS

SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(c) In the case of individuals who first satisfy paragraph (1) or (2) of section [1836] 1836(a) before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section [1836] 1836(a) but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) In the case of an individual who first satisfies paragraph (1) or (2) of section [1836] 1836(a) on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).

(e) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Any individual—

(1) who is eligible under section ~~1836~~ 1836(a) to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(b), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(d)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(i)(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section **【1836】 1836(a)**, is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section **【1836】 1836(a)**, is enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A);

(B) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or individual's spouse's) current employment status; and

(C) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment status,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of current employment status ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 226(b) and—

(i) who at the time the individual first satisfies paragraph (1) of section **[1836]** *1836(a)*—

(I) is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's current or former employment or by reason of the current or former employment status of a member of the individual's family, and

(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).

(j) In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 226(h), the following special rules apply:

(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section **[1836(1)]** *1836(a)(1)*.

(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.

(k)(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section **[1836]** *1836(a)*, is described in paragraph (3), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; or

(B) has terminated enrollment under this section during a month in which the individual is described in paragraph (3),

there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph is the 6-month period beginning on the first day of the month which includes the date that the individual is no longer described in paragraph (3).

(3) For purposes of paragraph (1), an individual described in this paragraph is an individual who—

(A) is serving as a volunteer outside of the United States through a program—

(i) that covers at least a 12-month period; and

(ii) that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

(B) demonstrates health insurance coverage while serving in the program.

(1)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.

(m)(1) Any individual who is eligible for coverage of immunosuppressive drugs under section 1836(b) may enroll or be deemed to have enrolled only in such manner and form as may be prescribed by regulations, and only during an enrollment period described in this subsection.

(2) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 226A(b)(2) prior to January 1, 2023, may enroll beginning on

October 1, 2022, or the day on which the individual first satisfies section 1836(b), whichever is later.

(3) An individual described in paragraph (1) whose entitlement for hospital insurance benefits under part A ends by reason of section 226A(b)(2) on or after January 1, 2023, shall be deemed to have enrolled in the medical insurance program established by this part for purposes of coverage of immunosuppressive drugs.

(4) The Secretary shall establish a process under which an individual described in paragraph (1) whose other coverage described in section 1836(b)(2)(A), or coverage under this part (including the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs) is terminated voluntarily or involuntary may enroll or reenroll, if applicable, in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

COVERAGE PERIOD

SEC. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his “coverage period”) shall begin on whichever of the following is the latest:

(1) July 1, 1966, or (in the case of a disabled individual who has not attained age 65) July 1, 1973; or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section ~~1836~~ 1836(a), the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls; or

(3)(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section ~~1836~~ 1836(a) or July 1, 1973, whichever is later, or

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

(b) An individual’s coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1843(e)) take effect at the close of the month following the month in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) or section 1837(m)(3) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) or section 1837(m)(3) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the month following the month in which the notice is filed.

(c) In the case of an individual satisfying paragraph (1) of section **[1836]** 1836(a) whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3) or 1837(i)(4)(B)—

(1) in any month of the special enrollment period in which the individual is at any time enrolled in a plan (specified in subparagraph (A) or (B), as applicable, of section 1837(i)(3) or specified in section 1837(i)(4)(A)(i)) or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(2) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(f) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section

1837(k), the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

(g) In the case of an individual described in section 1836(b)(1), the following rules shall apply:

(1) In the case of such an individual who is deemed to have enrolled in part B for coverage of immunosuppressive drugs under section 1837(m)(3), such individual's coverage period shall begin on the first day of the month in which the individual first satisfies section 1836(b).

(2) In the case of such an individual who enrolls (or reenrolls, if applicable) in part B for coverage of immunosuppressive drugs under paragraph (2) or (4) of section 1837(m), such individual's coverage period shall begin on January 1, 2023, or the month following the month in which the individual so enrolls (or reenrolls), whichever is later.

(3) The provisions of subsections (b) and (d) shall apply with respect to an individual described in paragraph (1) or (2).

(4) In addition to the reasons for termination under subsection (b), the coverage period of an individual described in paragraph (1) or (2) shall end when the individual becomes entitled to benefits under this title under section 226(a) or 226A or is no longer eligible for such coverage as a result of the application of section 1836(b)(2).

(5) The Secretary may conduct public education activities to raise awareness of the availability of more comprehensive, qualified health plans for individuals eligible under section 1836(b) to enroll or to be deemed enrolled in the medical insurance program established under this part for purposes of coverage of immunosuppressive drugs.

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Subject to paragraphs (5) and (6), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin. In applying this paragraph there shall not be taken into account additional payments under section 1848(o) and section 1853(l)(3) and the Government contribution under section 1844(a)(3).

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), (f), and (i), and to reflect any credit provided under section 1854(b)(1)(C)(ii)(III).

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that (except as provided in subsection (g)) is equal

to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium rate for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1).

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(5)(A) In applying this part (including subsection (i) and section 1833(b)), the monthly actuarial rate for enrollees age 65 and over for 2016 shall be determined as if subsection (f) did not apply.

(B) Subsection (f) shall continue to be applied to paragraph (6)(A) (during a repayment month, as described in paragraph (6)(B)) and without regard to the application of subparagraph (A).

(6)(A) With respect to a repayment month (as described in subparagraph (B)), the monthly premium otherwise established under paragraph (3) shall be increased by, subject to subparagraph (D), §3.

(B) For purposes of this paragraph, a repayment month is a month during a year, beginning with 2016, for which a balance due amount is computed under subparagraph (C) as greater than zero.

(C) For purposes of this paragraph, the balance due amount computed under this subparagraph, with respect to a month, is the amount estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services to be equal to—

(i) the amount transferred under section 1844(d)(1); plus

(ii) the amount that is equal to the aggregate reduction, for all individuals enrolled under this part, in the income related monthly adjustment amount as a result of the application of paragraph (5); minus

(iii) the amounts payable under this part as a result of the application of this paragraph for preceding months.

(D) If the balance due amount computed under subparagraph (C), without regard to this subparagraph, for December of a year would be less than zero, the Chief Actuary of the Centers for Medicare & Medicaid Services shall estimate, and the Secretary shall apply, a reduction to the dollar amount increase applied under subparagraph (A) for each month during such year in a manner such that the balance due amount for January of the subsequent year is equal to zero.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under subsection (i)(4) or (l) of section 1837, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iii)) or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence. *No increase in the premium shall be effected for individuals who are enrolled pursuant to section 1836(b) for coverage only of immunosuppressive drugs.*

(c) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) For purposes of subsection (b) (and section 1837(g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section **[1836]** 1836(a) and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section **[1836]** 1836(a) and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

(e)(1) Upon the request of a State (or any appropriate State or local governmental entity specified by the Secretary), the Secretary may enter into an agreement with the State (or such entity) under

which the State (or such entity) agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

(3) In this subsection:

(A) The term “eligible individual” means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

(B) The term “part B late enrollment premium increase” means any increase in a premium as a result of the application of subsection (b).

(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), and if the amount of the individual’s premium is not adjusted for such January under subsection (i), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.

(g) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to—

(1) the application of section 1861(v)(1)(L)(viii) or to the establishment under section 1861(v)(1)(L)(i)(V) of a per visit limit at 106 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being made under section 1895 (relating to prospective payment for home health services); and

(2) the medicare prescription drug discount card and transitional assistance program under section 1860D–31.

(h) POTENTIAL APPLICATION OF COMPARATIVE COST ADJUSTMENT IN CCA AREAS.—

(1) IN GENERAL.—Certain individuals who are residing in a CCA area under section 1860C–1 who are not enrolled in an MA plan under part C may be subject to a premium adjust-

ment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

(2) NO EFFECT ON LATE ENROLLMENT PENALTY OR INCOME-RELATED ADJUSTMENT IN SUBSIDIES.—Nothing in this subsection or section 1860C–1(f) shall be construed as affecting the amount of any premium adjustment under subsection (b) or (i). Subsection (f) shall be applied without regard to any premium adjustment referred to in paragraph (1).

(3) IMPLEMENTATION.—In order to carry out a premium adjustment under this subsection and section 1860C–1(f) (insofar as it is effected through the manner of collection of premiums under section 1840(a)), the Secretary shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the name, social security account number, and the amount of the premium adjustment (if any) for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(i) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

(1) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount under paragraph (2), the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in paragraph (3).

(2) THRESHOLD AMOUNT.—For purposes of this subsection, subject to paragraph (6), the threshold amount is—

(A) except as provided in subparagraph (B), \$80,000 (or, beginning with 2018, \$85,000), and

(B) in the case of a joint return, twice the amount applicable under subparagraph (A) for the calendar year.

(3) MONTHLY ADJUSTMENT AMOUNT.—

(A) IN GENERAL.—Subject to subparagraph (B), the monthly adjustment amount specified in this paragraph for an individual for a month in a year is equal to the product of the following:

(i) SLIDING SCALE PERCENTAGE.—Subject to paragraph (6), the applicable percentage specified in the applicable table in subparagraph (C) for the individual minus 25 percentage points.

(ii) UNSUBSIDIZED PART B PREMIUM AMOUNT.—

(I) 200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year); plus

(II) 4 times the amount of the increase in the monthly premium under subsection (a)(6) for a month in the year.

(B) 3-YEAR PHASE IN.—The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2009 is equal to the following percentage of the monthly adjustment amount specified in subparagraph (A):

- (i) For 2007, 33 percent.
- (ii) For 2008, 67 percent.
- (C) APPLICABLE PERCENTAGE.—
 - (i) IN GENERAL.—
 - (I) Subject to paragraphs (5) and (6), for years before 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than \$80,000 but not more than \$100,000	35 percent
More than \$100,000 but not more than \$150,000	50 percent
More than \$150,000 but not more than \$200,000	65 percent
More than \$200,000	80 percent.

(II) Subject to paragraph (5), for 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than \$85,000 but not more than \$107,000	35 percent
More than \$107,000 but not more than \$133,500	50 percent
More than \$133,500 but not more than \$160,000	65 percent
More than \$160,000	80 percent.

(III) Subject to paragraph (5), for years beginning with 2019:

If the modified adjusted gross income is:	The applicable percentage is:
More than \$85,000 but not more than \$107,000	35 percent
More than \$107,000 but not more than \$133,500	50 percent
More than \$133,500 but not more than \$160,000	65 percent
More than \$160,000 but less than \$500,000	80 percent
At least \$500,000	85 percent.

(ii) JOINT RETURNS.—In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year except, with respect to the dollar amounts applied in the last row of the table under subclause (III) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 150 percent of such dollar amounts for the calendar year.

(iii) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—In the case of an individual who—

(I) is married as of the close of the taxable year (within the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

(II) does not live apart from such individual's spouse at all times during the taxable year, clause (i) shall be applied by reducing each of the dollar amounts otherwise applicable under such clause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

(4) MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—For purposes of this subsection, the term “modified adjusted gross income” means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code.

In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

(B) TAXABLE YEAR TO BE USED IN DETERMINING MODIFIED ADJUSTED GROSS INCOME.—

(i) IN GENERAL.—In applying this subsection for an individual's premiums in a month in a year, subject to clause (ii) and subparagraph (C), the individual's modified adjusted gross income shall be such income determined for the individual's last taxable year beginning in the second calendar year preceding the year involved.

(ii) TEMPORARY USE OF OTHER DATA.—If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

(iii) NON-FILERS.—In the case of individuals with respect to whom the Secretary of the Treasury does not have adequate data in appropriate electronic form for either taxable year referred to in clause (i) or clause (ii), the Commissioner of Social Security, in consultation with the Secretary, shall prescribe regulations which provide for the treatment of the premium adjustment with respect to such individual under this subsection, including regulations which provide for—

(I) the application of the highest applicable percentage under paragraph (3)(C) to such individual if the Commissioner has information which indicates that such individual's modified adjusted gross income might exceed the threshold amount for the taxable year referred to in clause (i), and

(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent with such individual's modified adjusted gross income for such taxable year.

(C) USE OF MORE RECENT TAXABLE YEAR.—

(i) IN GENERAL.—The Commissioner of Social Security in consultation with the Secretary of the Treasury shall establish a procedures under which an individual's modified adjusted gross income shall, at the request of such individual, be determined under this subsection—

(I) for a more recent taxable year than the taxable year otherwise used under subparagraph (B), or

(II) by such methodology as the Commissioner, in consultation with such Secretary, determines to be appropriate, which may include a methodology for aggregating or disaggregating information from tax returns in the case of marriage or divorce.

(ii) STANDARD FOR GRANTING REQUESTS.—A request under clause (i)(I) to use a more recent taxable year may be granted only if—

(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

(5) INFLATION ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (C), in the case of any calendar year beginning after 2007 (other than 2018 and 2019), each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year ex-

ceeds such average for the 12-month period ending with August 2006 (or, in the case of a calendar year beginning with 2020, August 2018).

(B) ROUNDING.—If any dollar amount after being increased under subparagraph (A) or (C) is not a multiple of \$1,000, such dollar amount shall be rounded to the nearest multiple of \$1,000.

(C) TREATMENT OF ADJUSTMENTS FOR CERTAIN HIGHER INCOME INDIVIDUALS.—

(i) IN GENERAL.—Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of \$500,000.

(ii) ADJUSTMENT BEGINNING 2028.—In the case of any calendar year beginning after 2027, each dollar amount in paragraph (3) of \$500,000 shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2026.

(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2017—

(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

(7) JOINT RETURN DEFINED.—For purposes of this subsection, the term “joint return” has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

(j) DETERMINATION OF PREMIUM FOR INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—*The Secretary shall, during September of each year (beginning with 2022), determine and promulgate a monthly premium rate for the succeeding calendar year for individuals enrolled only for the purpose of coverage of immunosuppressive drugs under section 1836(b). Such premium shall be equal to 35 percent of the monthly actuarial rate for enrollees age 65 and over (as would be determined in accordance with subsection (a)(1) if the reference to “one-half” in such subsection were a reference to “100 percent”) for that succeeding calendar year. The monthly premium of each individual enrolled for coverage of immunosuppressive drugs under section 1836(b) for each month shall be the amount promulgated in this subsection. Such amount shall be adjusted in accordance with subsections (c), (f), and (i), but shall not be adjusted under subsection (b).*

* * * * *

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM
 Subpart 1—Part D Eligible Individuals and Prescription Drug
 Benefits

ELIGIBILITY, ENROLLMENT, AND INFORMATION

SEC. 1860D-1. (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG
 COVERAGE THROUGH ENROLLMENT IN PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D-2(a)) as follows:

(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D-41(a)(14)).

(B) MEDICARE ADVANTAGE ENROLLEES.—

(i) ENROLLEES IN A PLAN PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE RECEIVE COVERAGE THROUGH THE PLAN.—A part D eligible individual who is enrolled in an MA-PD plan obtains such coverage through such plan.

(ii) LIMITATION ON ENROLLMENT OF MA PLAN ENROLLEES IN PRESCRIPTION DRUG PLANS.—Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

(iii) PRIVATE FEE-FOR-SERVICE ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1859(b)(2)) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(iv) ENROLLEES IN MSA PLANS PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MSA plan (as defined in section 1859(b)(3)) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(2) COVERAGE FIRST EFFECTIVE JANUARY 1, 2006.—Coverage under prescription drug plans and MA-PD plans shall first be effective on January 1, 2006.

(3) DEFINITIONS.—For purposes of this part:

(A) PART D ELIGIBLE INDIVIDUAL.—The term “part D eligible individual” means an individual who is entitled to benefits under part A or enrolled under part B (*but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1836(b)*).

(B) MA PLAN.—The term “MA plan” has the meaning given such term in section 1859(b)(1).

(C) MA-PD PLAN.—The term “MA-PD plan” means an MA plan that provides qualified prescription drug coverage.

(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

(1) ESTABLISHMENT OF PROCESS.—

(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

(B) APPLICATION OF MA RULES.—In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA-PD plan under the following provisions of section 1851:

(i) RESIDENCE REQUIREMENTS.—Section 1851(b)(1)(A), relating to residence requirements.

(ii) EXERCISE OF CHOICE.—Section 1851(c) (other than paragraph (3)(A) and paragraph (4) of such section), relating to exercise of choice.

(iii) COVERAGE ELECTION PERIODS.—Subject to paragraphs (2) and (3) of this subsection, section 1851(e) (other than subparagraphs (B), (C), (E), and (F) of paragraph (2) and the second sentence of paragraph (4) of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

(iv) COVERAGE PERIODS.—Section 1851(f), relating to effectiveness of elections and changes of elections.

(v) GUARANTEED ISSUE AND RENEWAL.—Section 1851(g) (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

(vi) MARKETING MATERIAL AND APPLICATION FORMS.—Section 1851(h), relating to approval of marketing material and application forms.

In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1851(e) shall be treated as a reference to such section as applied pursuant to clause (iii) of this subparagraph.

(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, except as provided in subparagraph (D), in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D-14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMIS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

(2) INITIAL ENROLLMENT PERIOD.—

(A) PROGRAM INITIATION.—In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1851(e)(3)(B)(iii), as applied under paragraph (1)(B)(iii).

(B) CONTINUING PERIODS.—In the case of an individual who becomes a part D eligible individual after November 15, 2005, there shall be an initial enrollment period which is the period under section 1851(e)(1), as applied under paragraph (1)(B)(iii) of this section, as if “entitled to benefits under part A or enrolled under part B” were substituted for “entitled to benefits under part A and enrolled under part B”, but in no case shall such period end before the period described in subparagraph (A).

(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

(A) INVOLUNTARY LOSS OF CREDITABLE PRESCRIPTION DRUG COVERAGE.—

(i) IN GENERAL.—In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1860D–13(b)(4)).

(ii) NOTICE.—In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

(iii) FAILURE TO PAY PREMIUM.—For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

(iv) REDUCTION IN COVERAGE.—For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1860D–13(b)(5) (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

(B) ERRORS IN ENROLLMENT.—In the case described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B.

(C) EXCEPTIONAL CIRCUMSTANCES.—In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

(D) MEDICAID COVERAGE.—In the case of an individual (as determined by the Secretary, subject to such limits as the Secretary may establish for individuals identified pursuant to section 1860D–4(c)(5)) who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)).

(E) DISCONTINUANCE OF MA–PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In the case of a part D eligible individual who discontinues enrollment in an MA–PD plan under the second sentence of section 1851(e)(4) at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

(4) INFORMATION TO FACILITATE ENROLLMENT.—

(A) IN GENERAL.—Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA–PD plans to such individuals and enrollment of such individuals in such plans.

(B) LIMITATION.—

(i) PROVISION OF INFORMATION.—The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

(ii) USE OF INFORMATION.—Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA–PD plans.

(5) REFERENCE TO ENROLLMENT PROCEDURES FOR MA–PD PLANS.—For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA–PD plans, see section 1851.

(6) REFERENCE TO PENALTIES FOR LATE ENROLLMENT.—Section 1860D–13(b) imposes a late enrollment penalty for part D eligible individuals who—

(A) enroll in a prescription drug plan or an MA–PD plan after the initial enrollment period described in paragraph (2); and

(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

(c) PROVIDING INFORMATION TO BENEFICIARIES.—

(1) ACTIVITIES.—The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior to the initial enrollment period described in subsection (b)(2)(A).

(2) REQUIREMENTS.—The activities described in paragraph (1) shall—

(A) be similar to the activities performed by the Secretary under section 1851(d), including dissemination (including through the toll-free telephone number 1-800-MEDICARE) of comparative information for prescription drug plans and MA-PD plans; and

(B) be coordinated with the activities performed by the Secretary under such section and under section 1804.

(3) COMPARATIVE INFORMATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

(i) BENEFITS.—The benefits provided under the plan.

(ii) MONTHLY BENEFICIARY PREMIUM.—The monthly beneficiary premium under the plan.

(iii) QUALITY AND PERFORMANCE.—The quality and performance under the plan.

(iv) BENEFICIARY COST-SHARING.—The cost-sharing required of part D eligible individuals under the plan.

(v) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1860D-4(d).

(B) EXCEPTION FOR UNAVAILABILITY OF INFORMATION.—The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

(i) for the first plan year in which it is offered; and

(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

(4) INFORMATION ON LATE ENROLLMENT PENALTY.—The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1860D-13(b).

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution,

to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
 - (ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,
 - (iii) 65 years of age or older,
 - (iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,
 - (v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,
 - (vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,
 - (vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,
 - (viii) pregnant women,
 - (ix) individuals provided extended benefits under section 1925,
 - (x) individuals described in section 1902(u)(1),
 - (xi) individuals described in section 1902(z)(1),
 - (xii) employed individuals with a medically improved disability (as defined in subsection (v)),
 - (xiii) individuals described in section 1902(aa),
 - (xiv) individuals described in section 1902(a)(10)(A)(i)(VIII) or 1902(a)(10)(A)(i)(IX),
 - (xv) individuals described in section 1902(a)(10)(A)(ii)(XX),
 - (xvi) individuals described in section 1902(ii), or
 - (xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,
- but whose income and resources are insufficient to meet all of such cost—
- (1) inpatient hospital services (other than services in an institution for mental diseases);
 - (2)(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (1)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (1)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (1)(2)) and any other ambulatory services offered

by a Federally-qualified health center and which are otherwise included in the plan;

(3)(A) other laboratory and X-ray services; and

(B) in vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) administered during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) beginning on or after the date of the enactment of this subparagraph for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such in vitro diagnostic products;

(4)(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb));

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1));

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by

the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31), to be in need of such care;

(16) (A) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h), and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph;

(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1915(g)(2)) and TB-related services described in section 1902(z)(2)(F);

(20) respiratory care services (as defined in section 1902(e)(9)(C));

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1930);

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institu-

tion for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

(28) freestanding birth center services (as defined in subsection (1)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(3)(B)) and that are otherwise included in the plan;

(29) subject to paragraph (2) of subsection (ee), for the period beginning October 1, 2020, and ending September 30, 2025, medication-assisted treatment (as defined in paragraph (1) of such subsection); and

(30) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases (except in the case of services provided under a State plan amendment described in section 1915(l)).

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not en-

rolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency. In the case of a woman who is eligible for medical assistance on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), who is a patient in an institution for mental diseases for purposes of receiving treatment for a substance use disorder, and who was enrolled for medical assistance under the State plan immediately before becoming a patient in an institution for mental diseases or who becomes eligible to enroll for such medical assistance while such a patient, the exclusion from the definition of "medical assistance" set forth in the subdivision (B) following paragraph (30) of the first sentence of this subsection shall not be construed as prohibiting Federal financial participation for medical assistance for items or services that are provided to the woman outside of the institution.

(b) Subject to subsections (y), (z), (aa), and (ff) and section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII), and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expendi-

tures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b). Notwithstanding the first sentence of this subsection, the Federal medical assistance percentage shall be 100 per centum with respect to (and, notwithstanding any other provision of this title, available for) medical assistance provided to uninsured individuals (as defined in section 1902(ss)) who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XXIII) and with respect to expenditures described in section 1903(a)(7) that a State demonstrates to the satisfaction of the Secretary are attributable to administrative costs related to providing for such medical assistance to such individuals under the State plan.

(c) For definition of the term "nursing facility", see section 1919(a).

(d) The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) For purposes of this title, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided

directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits,

as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(1)(1) The terms “rural health clinic services” and “rural health clinic” have the meanings given such terms in section 1861(aa), except that (A) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (B) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term “Federally-qualified health center services” means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as a patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term “Federally-qualified health center” means an entity which—

(i) is receiving a grant under section 330 of the Public Health Service Act,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 330 of such Act,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of title XVIII, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

(3)(A) The term “freestanding birth center services” means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term “freestanding birth center” means a health facility—

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman's residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a free-standing birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term "birth attendant" means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.

(m)(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family that would be receiving aid under the State plan under part A of title IV pursuant to section 407 if the State had not exercised the option under section 407(b)(2)(B)(i).

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

(o)(1)(A) Subject to subparagraphs (B) and (C), the term "hospice care" means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with

paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this title, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

(2) An individual's voluntary election under this subsection —

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual—

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1902(a)(13)(B) and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4).

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not in-

cluding an individual entitled to such benefits only pursuant to an enrollment under section 1818A) or who is enrolled under part B for the purpose of coverage of immunosuppressive drugs under section 1836(b),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3) (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 85 percent,
- (ii) January 1, 1990, is 90 percent, and
- (iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

- (i) January 1, 1989, is 80 percent,
- (ii) January 1, 1990, is 85 percent,
- (iii) January 1, 1991, is 95 percent, and
- (iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified

medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A, and

(ii) premiums under section 1839,

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to “80 percent” therein were deemed a reference to “100 percent”.

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) of such paragraph or 1902(a)(10)(E)(iii) any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1144.

(q) The term “qualified severely impaired individual” means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits

under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this title; and
 (2) with respect to whom the Commissioner of Social Security determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines) according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

- (v) health education (including anticipatory guidance).
- (2) Vision services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.
- (3) Dental services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.
- (4) Hearing services—
 - (A) which are provided—
 - (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
 - (B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.
- (5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.

(s) The term “qualified disabled and working individual” means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance under this title.

(t)(1) The term “primary care case management services” means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term “primary care case manager” means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in section 1905(a)(21));

(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

(iii) a physician assistant (as defined in section 1861(aa)(5)).

(3) The term “primary care case management contract” means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment,

disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1932(a)(4); and

(F) complies with the other applicable provisions of section 1932.

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 2105(d)(1).

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b).

(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term “optional targeted low-income child” means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(1)(1)(D)). Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).

(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(1)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(v)(1) The term “employed individual with a medically improved disability” means an individual who—

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1902(a)(10)(A)(ii)(XV) because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 223(d) or 1614(a)(3); and

- (D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.
- (2) For purposes of paragraph (1), an individual is considered to be “employed” if the individual—
- (A) is earning at least the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act (29 U.S.C. 206) and working at least 40 hours per month; or
 - (B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.’
- (w)(1) For purposes of this title, the term “independent foster care adolescent” means an individual—
- (A) who is under 21 years of age;
 - (B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and
 - (C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).
- (2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1931(b).
- (3) A State may limit the eligibility of independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.
- (x) For purposes of subsection (a)(27), the strategies, treatment, and services described in that subsection include the following:
- (1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.
 - (2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.
 - (3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.
- (y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—
- (1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—
- (A) 100 percent for calendar quarters in 2014, 2015, and 2016;
 - (B) 95 percent for calendar quarters in 2017;
 - (C) 94 percent for calendar quarters in 2018;
 - (D) 93 percent for calendar quarters in 2019; and
 - (E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) DEFINITIONS.—In this subsection:

(A) NEWLY ELIGIBLE.—The term “newly eligible” means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) FULL BENEFITS.—The term “full benefits” means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).

(z) EQUITABLE SUPPORT FOR CERTAIN STATES.—

(1)(A) During the period that begins on January 1, 2014, and ends on December 31, 2015, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—

(i) is an expansion State described in paragraph (3);

(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and

(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

(2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are non-pregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 shall be equal to the percent specified in subparagraph (B)(i) for such year.

(B)(i) The percent specified in this subparagraph for a State for a year is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to the transition percentage (specified in clause (ii) for the year) of the number of percentage points by which—

- (I) such Federal medical assistance percentage for the State, is less than
 - (II) the percent specified in subsection (y)(1) for the year.
- (ii) The transition percentage specified in this clause for—
- (I) 2014 is 50 percent;
 - (II) 2015 is 60 percent;
 - (III) 2016 is 70 percent;
 - (IV) 2017 is 80 percent;
 - (V) 2018 is 90 percent; and
 - (VI) 2019 and each subsequent year is 100 percent.

(3) A State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

(aa)(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP shall be increased by 50 percent of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5.

(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for such fiscal year shall be increased by 25 percent (or 50 percent in the case of fiscal year 2013) of the number of percentage points by which the State's regular FMAP for such fiscal year is less than the Federal medical assistance percentage received by the State during the preceding fiscal year.

(2) In this subsection, the term "disaster-recovery FMAP adjustment State" means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section

401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which—

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsections (y) and (z), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the State's regular FMAP for the fiscal year is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

(3) In this subsection, the term "regular FMAP" means, for each fiscal year for which this subsection applies to a State, the Federal medical assistance percentage that would otherwise apply to the State for the fiscal year, as determined under subsection (b) and without regard to this subsection, subsections (y) and (z), and section 10202 of the Patient Protection and Affordable Care Act.

(4) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.

(bb)(1) For purposes of this title, the term "counseling and pharmacotherapy for cessation of tobacco use by pregnant women" means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and non-prescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

(A) by or under the supervision of a physician; or

(B) by any other health care professional who—

(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

(2) Subject to paragraph (3), such term is limited to—

(A) services recommended with respect to pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline", published by the Public Health

Service in May 2008, or any subsequent modification of such Guideline; and

(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.

(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009 and section 6008 of the Families First Coronavirus Response Act, except that in applying such treatments to the increases in the Federal medical assistance percentage under section 6008 of the Families First Coronavirus Response Act, the reference to “December 31, 2009” shall be deemed to be a reference to “March 11, 2020”.

(dd) INCREASED FMAP FOR ADDITIONAL EXPENDITURES FOR PRIMARY CARE SERVICES.—Notwithstanding subsection (b), with respect to the portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2013, and before January 1, 2015, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of July 1, 2009, the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia shall be equal to 100 percent. The preceding sentence does not prohibit the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified in such sentence.

(ee) MEDICATION-ASSISTED TREATMENT.—

(1) DEFINITION.—For purposes of subsection (a)(29), the term “medication-assisted treatment”—

(A) means all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and

(B) includes, with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

(2) EXCEPTION.—The provisions of paragraph (29) of subsection (a) shall not apply with respect to a State for the period specified in such paragraph, if before the beginning of such period the State certifies to the satisfaction of the Secretary that implementing such provisions statewide for all individuals eligible to enroll in the State plan (or waiver of the State plan) would not be feasible by reason of a shortage of qualified providers of medication-assisted treatment, or facilities providing such treatment, that will contract with the State or a managed care entity with which the State has a contract under section 1903(m) or under section 1905(t)(3).

(ff) TEMPORARY INCREASE IN FMAP FOR TERRITORIES FOR CERTAIN FISCAL YEARS.—Notwithstanding subsection (b) or (z)(2)—

(1) for the period beginning October 1, 2019, and ending December 20, 2019, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 100 percent;

(2) subject to section 1108(g)(7)(C), for the period beginning December 21, 2019, and ending September 30, 2021, the Federal medical assistance percentage for Puerto Rico shall be equal to 76 percent; and

(3) subject to section 1108(g)(8)(B), for the period beginning December 21, 2019, and ending September 30, 2021, the Federal medical assistance percentage for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be equal to 83 percent.

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