

112TH CONGRESS
2D SESSION

S. 3673

To provide a comprehensive deficit reduction plan, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 12, 2012

Mr. CORKER introduced the following bill; which was read twice and referred
to the Committee on Finance

A BILL

To provide a comprehensive deficit reduction plan, and for
other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “The Dollar for Dollar Act of 2012”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICAID

Sec. 1101. Comprehensive Medicaid Waivers.

Sec. 1102. Phased-in elimination of allowable provider taxes under Medicaid.

TITLE II—MEDICARE

Subtitle A—Medicare Total Health Program; Medicare Fee-for-Service Program Reforms; Reports

Sec. 2000. Short title; purpose.

PART I—MEDICARE TOTAL HEALTH PROGRAM

Sec. 2001. Establishment of Medicare Total Health program.

Sec. 2002. Replacement of part B premium with Medicare Total Health program plan premium; other technical and conforming amendments.

PART II—MEDICARE FEE-FOR-SERVICE REFORMS

Sec. 2011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits.

Sec. 2012. Unified Medicare deductible.

Sec. 2013. Uniform Medicare coinsurance rate.

Sec. 2014. Prohibition on first-dollar coverage under Medigap policies and development of new standards for Medigap policies.

PART III—ANNUAL REPORT TO CONGRESS

Sec. 2021. Annual report to Congress.

Subtitle B—Elimination of Exemption of Medicare Payments to Physicians Under Statutory PAYGO

Sec. 2101. Elimination of exemption of Medicare payments to physicians under statutory PAYGO.

Subtitle C—Adjustments to Medicare Part B and D Premiums for High-Income Beneficiaries

Sec. 2201. Adjustments to Medicare part B and D premiums for high-income beneficiaries.

Subtitle D—Increase in the Medicare Eligibility Age

Sec. 2301. Increase in the Medicare eligibility age.

Subtitle E—Other Provisions

Sec. 2401. Limitation on Medicare payments for direct graduate medical education (DGME).

Sec. 2402. Reduction in Medicare indirect graduate medical education (IME) payments.

Sec. 2403. Acceleration of application of productivity adjustment to Medicare home health prospective payment amounts.

Sec. 2404. Acceleration of rebasing of Medicare home health prospective payment amounts.

Sec. 2405. Reduction of bad debt treated as an allowable cost.

TITLE III—SOCIAL SECURITY

Sec. 3101. Adjustments to bend points in determining primary insurance amount.

Sec. 3102. Adjustment to calculation of benefit computation years.

Sec. 3103. Minimum social security benefit.

- Sec. 3104. Increase in benefits starting 20 years after initial eligibility.
- Sec. 3105. Adjustment to normal and early retirement ages.
- Sec. 3106. Application of actuarial reduction for disabled beneficiaries who attain early retirement age.
- Sec. 3107. Option to collect up to one-half of old-age insurance benefit at age 62.
- Sec. 3108. Coverage of newly hired state and local employees.
- Sec. 3109. Inclusion in annual social security account statement of estimated present value of taxes and benefits for Social Security and Medicare and projected deficit as a percent of lifetime earnings.
- Sec. 3110. Retirement information campaign.

TITLE IV—CONVERSION TO CHAINED CPI

- Sec. 4101. Conversion to chained CPI.

TITLE V—PUBLIC DEBT LIMIT

- Sec. 5101. Increase in public debt limit.

1 **TITLE I—MEDICAID**

2 **SEC. 1101. COMPREHENSIVE MEDICAID WAIVERS.**

3 Section 1115 of the Social Security Act (42 U.S.C.
4 1315) is amended by adding at the end the following:

5 “(g) COMPREHENSIVE MEDICAID WAIVERS.—

6 “(1) AUTHORITY.—

7 “(A) IN GENERAL.—A State may elect to
8 provide medical assistance under title XIX, di-
9 rectly or by contract, to eligible individuals pur-
10 suant to a comprehensive Medicaid waiver
11 under this subsection in lieu of providing such
12 assistance under a State plan approved under
13 title XIX or a waiver approved under subsection
14 (d) or extended under subsection (e). A State
15 shall make such an election by submitting a
16 waiver application to the Secretary for certifi-

1 cation that the application satisfies the require-
2 ments of paragraph (2).

3 “(B) WAIVER OF STATE MEDICAID PRO-
4 GRAM REQUIREMENTS.—Any requirements ap-
5 plicable under this title or title XIX that would
6 prevent a State from carrying out a comprehen-
7 sive Medicaid waiver in accordance with the
8 State’s certified application and the require-
9 ments of this subsection are deemed waived.

10 “(C) SHARED SAVINGS BONUS.—A State
11 conducting a comprehensive Medicaid waiver
12 under this subsection shall be eligible for a
13 shared savings bonus in accordance with para-
14 graph (4).

15 “(D) OPTION TO INCLUDE CHIP-ELIGIBLE
16 INDIVIDUALS.—A State may elect to treat indi-
17 viduals eligible for child health assistance under
18 the State child health plan under title XXI as
19 eligible individuals under a comprehensive Med-
20 icaid waiver. The waiver application and deter-
21 mination of the aggregate spending cap for the
22 State for the waiver period shall take into ac-
23 count the inclusion of such individuals in the
24 comprehensive Medicaid waiver. Any require-
25 ments applicable under this title, title XIX, or

1 title XXI that would prevent a State from in-
 2 cluding such individuals in the comprehensive
 3 Medicaid waiver in accordance with the State's
 4 certified application and the requirements of
 5 this subsection are deemed waived.

6 “(2) COMPREHENSIVE MEDICAID WAIVER AP-
 7 PPLICATION.—An application for a comprehensive
 8 Medicaid waiver under this subsection shall contain
 9 the following:

10 “(A) GENERAL DESCRIPTION OF PRO-
 11 POSED BENEFIT DELIVERY MODELS, ELIGI-
 12 BILITY CRITERIA, AND BENEFITS.—A brief de-
 13 scription, which may be in outline form, of the
 14 eligibility criteria and medical assistance to be
 15 provided that includes the methods for delivery
 16 of such assistance, the criteria for the deter-
 17 mination of eligibility for such assistance, and
 18 the amount, duration, and scope of such assist-
 19 ance, including a description of the amount (if
 20 any) of premiums, deductibles, coinsurance, or
 21 other cost-sharing.

22 “(B) HEDIS MEASURES TO EVALUATE
 23 PERFORMANCE.—

24 “(i) IN GENERAL.—A description of
 25 not less than 20 of the standard Medicaid

1 Healthcare Effectiveness Data and Infor-
2 mation Set (HEDIS) measures established
3 by the National Committee for Quality As-
4 surance selected by the State to annually
5 evaluate the quality and cost-effectiveness
6 of the medical assistance provided under
7 the waiver, and for each such measure
8 (and, if applicable, the distinct rates asso-
9 ciated with the measure), the baseline data
10 and the target performance goal applicable
11 for each such measure or rate. The State
12 shall select HEDIS measures that are
13 closely aligned with the health care items
14 and services that are provided to eligible
15 individuals as medical assistance under the
16 waiver.

17 “(ii) EVALUATION.—The description
18 under this subparagraph shall specify the
19 independent entity that the State will use
20 to evaluate the waiver. The State shall pro-
21 vide an assurance that the State will sub-
22 mit a copy of the annual evaluation to the
23 Secretary.

1 “(C) PROGRAM INTEGRITY.—A brief de-
2 scription of the State’s program to prevent
3 waste, fraud, and abuse under the waiver.

4 “(D) AGGREGATE SPENDING CAP.—An as-
5 surance that the State agrees—

6 “(i) to establish categories that accu-
7 rately account for each of the distinct pop-
8 ulation groups that will qualify as eligible
9 individuals under the waiver (such as chil-
10 dren, parents, pregnant women, and the
11 blind or disabled) based on such criteria as
12 are determined appropriate by the State
13 (referred to in this subsection as a ‘popu-
14 lation category’);

15 “(ii) to provide the Secretary with all
16 data relevant to the determination of the
17 aggregate spending cap for the State for
18 the waiver period, as determined by the
19 Secretary under paragraph (3)(B); and

20 “(iii) with respect to each period for
21 which the waiver is approved, to not re-
22 ceive any Federal payments from the Sec-
23 retary for amounts expended during such
24 period that exceed the aggregate spending
25 cap.

1 “(3) DETERMINATION OF AGGREGATE SPEND-
2 ING CAP.—

3 “(A) ESTABLISHMENT OF SPENDING TEM-
4 PLATE.—

5 “(i) IN GENERAL.—The Secretary, in
6 coordination with the Director of the Of-
7 fice of Management and Budget (referred
8 to in this subsection as the ‘Director’),
9 shall establish a template for determining,
10 with respect to each State, the aggregate
11 spending cap for each period for which the
12 State conducts a comprehensive Medicaid
13 waiver under this subsection. The Sec-
14 retary shall—

15 “(I) publish a proposed template
16 not later than 60 days after the date
17 of enactment of this subsection;

18 “(II) provide for a period for
19 public comment on the proposed tem-
20 plate; and

21 “(III) promulgate a final tem-
22 plate not later than 120 days after
23 such date of enactment.

24 “(ii) REVISIONS.—

“(I) IN GENERAL.—Subject to subclause (II), the Secretary, in coordination with the Director, shall revise the template, as appropriate, not less than every 5 years pursuant to a process that allows for public comment prior to publication of the revised template.

“(II) TECHNICAL CHANGES.—The Secretary or the Director may make any necessary technical or conforming changes to the template at such times and in such manner as is determined appropriate.

“(B) DETERMINATION OF AGGREGATE SPENDING CAP FOR EACH STATE.—

“(i) IN GENERAL.—Subject to subparagraph (C), the aggregate spending cap applicable to a State for a waiver period shall be equal to 99 percent of the amount determined under clause (ii).

“(ii) TOTAL AMOUNT OF PROJECTED FEDERAL PAYMENTS.—The amount described in this clause is equal to the sum of—

1 “(I) the total amount of Federal
2 payments that would otherwise be
3 made to the State during the waiver
4 period with respect to any dispropor-
5 tionate share payment adjustment
6 made under section 1923; and

7 “(II) the sum of the amounts de-
8 termined under clause (iii) for each
9 population category.

10 “(iii) PROJECTED FEDERAL PAY-
11 MENTS FOR MEDICAL ASSISTANCE PRO-
12 VIDED TO POPULATION CATEGORIES.—For
13 purposes of clause (ii)(II), the Secretary
14 and the Director shall calculate the
15 amount of projected expenditures for the
16 provision of medical assistance to eligible
17 individuals in each population category
18 during the waiver period (as determined
19 based upon the population categories es-
20 tablished and the data provided by the
21 State pursuant to paragraph (2)(D), as
22 well as the annual baseline estimates sup-
23 plied by the Director and such other data
24 as is determined appropriate by the Sec-

1 retary), which shall be equal to the product
2 of—

3 “(I) subject to clause (iv), the
4 monthly per capita amount of Federal
5 payments that were made to the State
6 under the State plan under title XIX
7 (or under a waiver approved under
8 subsection (d) or extended under sub-
9 section (e)) for an individual in such
10 population category during the fiscal
11 year prior to the State application for
12 the waiver (referred to in this para-
13 graph as the ‘population category per
14 capita baseline’);

15 “(II) the number of individuals
16 within such population category that
17 are projected to be eligible to receive
18 medical assistance during the waiver
19 period; and

20 “(III) the number of months in
21 the waiver period.

22 “(iv) POPULATION CATEGORIES WITH
23 NO BASELINE DATA.—For purposes of any
24 determination under clause (iii)(I) for a
25 population category that lacks sufficient

1 data to calculate the population category
2 per capita baseline and that consists of in-
3 dividuals for which the State would other-
4 wise be required to provide medical assist-
5 ance to pursuant to section
6 1902(a)(10)(A)(i)(VIII), the population
7 category per capita baseline shall be equal
8 to the monthly per capita amount of Fed-
9 eral payments that would otherwise have
10 been made to the State under the State
11 plan under title XIX (or under a waiver
12 approved under subsection (d) or extended
13 under subsection (e)) during the preceding
14 fiscal year for an individual who is under
15 65 years of age, not pregnant, not entitled
16 to, or enrolled for, benefits under part A of
17 title XVIII, or enrolled for benefits under
18 part B of title XVIII.

19 “(v) BUDGET NEUTRALITY.—In no
20 event shall the aggregate spending cap es-
21 tablished for a State for a waiver period
22 allow for Federal payments to the State
23 during the waiver period that exceed the
24 amount of Federal payments to the State
25 that would have been made during that pe-

riod if the State had not elected to conduct
a comprehensive Medicaid waiver under
this subsection during the period.

“(C) ADJUSTMENT OF AGGREGATE SPENDING CAP FOR HIGH UNEMPLOYMENT.—For purposes of subparagraph (B)(i), if the average monthly unemployment rate (as defined in paragraph (8)(A)) for a State exceeds 10 percent for any consecutive period of at least 6 months occurring during the waiver period, the aggregate spending cap applicable to the State for such waiver period shall be equal to 100 percent of the amount determined under subparagraph (B)(ii).

“(4) SHARED SAVINGS BONUSES.—

“(A) IN GENERAL.—The Secretary shall annually pay each State conducting a comprehensive Medicaid waiver under this subsection an amount equal to 25 percent of the waiver savings determined with respect to a State and a waiver period under subparagraph (C).

“(B) DEDICATED TO HEALTH CARE.—A State that receives a payment under this paragraph shall spend not less than 80 percent of

1 the payment on health care services or health-
2 related activities for eligible individuals.

3 “(C) DETERMINATION OF WAIVER SAV-
4 INGS.—The Secretary and the Director shall es-
5 tablish a process for determining with respect
6 to a State and a waiver period the amount of
7 savings achieved by a State for the period. The
8 process shall take into account the difference
9 between the aggregate spending cap applicable
10 to the State for the waiver period and the total
11 amount expended by the State under the waiver
12 for the period.

13 “(D) PAYMENT; RETROSPECTIVE ADJUST-
14 MENT.—The Secretary shall make annual pay-
15 ments under this paragraph on the basis of
16 claims submitted by the State for expenses paid
17 by the State for medical assistance provided
18 under the waiver, and such other investigation
19 as the Secretary or the Director may find nec-
20 essary, and may reduce or increase the pay-
21 ments as necessary to adjust for prior overpay-
22 ments or under payments under this paragraph.

23 “(5) DURATION.—

24 “(A) IN GENERAL.—A State shall conduct
25 a comprehensive Medicaid waiver under this

subsection for a 5-year period. Subject to subparagraph (B), a comprehensive Medicaid waiver may be renewed for additional 3-year periods upon the request of the State, unless within 90 days after receipt of a State request for a renewal of a waiver, the Secretary and the Director determine, based on the State evaluations required under paragraph (2)(B), that the waiver should not be renewed.

“(B) STATE EVALUATIONS AND TARGET PERFORMANCE GOALS.—For purposes of subparagraph (A), the Secretary and the Director may not renew a waiver unless each of the measures or rates selected by the State pursuant to paragraph (2)(B) has improved or remained constant during the waiver period.

“(6) LIMITED SECRETARIAL AUTHORITY; ADMINISTRATIVE AND JUDICIAL REVIEW.—

“(A) CERTIFICATION OF WAIVER APPLICATIONS.—

“(i) IN GENERAL.—Except as provided under clause (ii), the Secretary and the Director shall have 90 days from receipt of an application by a State for a comprehensive Medicaid waiver to certify

1 the application as satisfying the require-
2 ments of paragraph (2).

3 “(ii) INQUIRIES.—The Secretary and
4 the Director may submit a single set of in-
5 quiries for additional information to the
6 State during the initial 90-day period de-
7 scribed under clause (i). If a State receives
8 a set of inquiries, the State shall have up
9 to 60 days to respond. The Secretary and
10 the Director shall have an additional 30-
11 day period, starting on the date the Sec-
12 retary receives a State response to a set of
13 inquiries, to make a final determination as
14 to whether the State’s waiver application
15 may be certified as complying with the re-
16 quirements of paragraph (2).

17 “(iii) FAILURE TO RESPOND BY THE
18 SECRETARY.—An application by a State
19 for a comprehensive Medicaid waiver shall
20 be deemed certified by the Secretary if the
21 Secretary does not submit any inquiries
22 during the initial 90-day review period.

23 “(iv) EFFECTIVE DATE.—A waiver
24 that has been certified by the Secretary (or
25 deemed to be certified) may be effective, at

1 the discretion of the State, as of the first
 2 day of the calendar quarter in which the
 3 application for the waiver was submitted
 4 by the State.

5 “(B) DENIAL OF WAIVER APPLICATIONS
 6 OR RENEWAL REQUESTS.—

7 “(i) IN GENERAL.—If the Secretary
 8 and the Director determine that an appli-
 9 cation for a comprehensive Medicaid waiv-
 10 er, or a request for extension of an existing
 11 comprehensive Medicaid waiver, does not
 12 satisfy the requirements of paragraph (2),
 13 the Secretary shall notify the State of the
 14 disapproval by written notification, not
 15 later than 10 days following the issuance
 16 of such determination and shall provide a
 17 detailed description of the reasons for the
 18 denial of the waiver to—

19 “(I) the State that submitted the
 20 waiver application or extension re-
 21 quest;

22 “(II) the members of Congress
 23 representing such State; and

24 “(III) the Committee on Finance
 25 of the Senate and the Committee on

1 Energy and Commerce of the House
2 of Representatives.

3 “(ii) ADMINISTRATIVE AND JUDICIAL
4 REVIEW.—

5 “(I) ADMINISTRATIVE REVIEW.—

6 Within 60 days after the date that a
7 State receives notice of the denial of a
8 waiver application or extension re-
9 quest, the State may appeal the deter-
10 mination to the Departmental Appeals
11 Board established in the Department
12 of Health and Human Services. The
13 Departmental Appeals Board shall
14 make a final determination with re-
15 spect to an appeal filed under this
16 subparagraph not less than 60 days
17 after the date on which the appeal is
18 filed.

19 “(II) JUDICIAL REVIEW.—Within
20 60 days after the date of a final deci-
21 sion by the Board under subclause (I)
22 that is adverse to a State, the State
23 may obtain judicial review of the final
24 decision by filing an action in the dis-
25 trict court of the United States for

1 the judicial district in which the prin-
2 cipal or headquarters office of the
3 State agency responsible for admin-
4 istering the State Medicaid program
5 is located or the United States Dis-
6 trict Court for the District of Colum-
7 bia.

8 “(C) REPORTS.—

9 “(i) IN GENERAL.—Not later than 2
10 years after the date on which the Secretary
11 and the Director first approve an applica-
12 tion for a comprehensive Medicaid waiver
13 under this subsection and every 3 years
14 thereafter, the Comptroller General of the
15 United States (referred to in this subpara-
16 graph as the ‘Comptroller’) shall submit to
17 the Committee on Finance of the Senate
18 and the Committee on Energy and Com-
19 merce of the House of Representatives a
20 report on the waivers certified as of the
21 date of such report. Each report shall in-
22 clude an evaluation of the quality and cost-
23 effectiveness of the comprehensive Med-
24 icaid waivers in effect during the reporting
25 period in providing medical assistance to

1 eligible individuals, as well as the financial
 2 effort of the waiver on State and Federal
 3 budgets.

4 “(ii) REPORTING OF INFORMATION.—

5 A State with a comprehensive Medicaid
 6 waiver under this subsection shall provide
 7 the Comptroller, in such form and manner
 8 as the Comptroller may require, with any
 9 relevant information regarding the waiver,
 10 including total expenditures by the State
 11 under the waiver, the number of individ-
 12 uals provided medical assistance under the
 13 waiver, and such other information as the
 14 Comptroller may require for purposes of
 15 preparing the reports required under this
 16 subparagraph.

17 “(7) NON-APPLICATIONS.—A comprehensive

18 Medicaid waiver shall not apply to—

19 “(A) the pediatric vaccine program under
 20 section 1928; and

21 “(B) limitations on total payments to terri-
 22 tories under section 1108.

23 “(8) OUTREACH AND EDUCATION.—

24 “(A) STATE AWARENESS.—Not later than
 25 30 days after the date of enactment of this sub-

1 section, the Secretary shall conduct an outreach
2 and education campaign to States regarding the
3 availability of comprehensive Medicaid waivers
4 under this subsection.

5 “(B) PUBLIC NOTICE AND COMMENT.—Be-
6 fore submitting an application for a comprehen-
7 sive Medicaid waiver, a State shall make the
8 proposed application available to the public
9 through such means as the State determines
10 appropriate and allow for a reasonable public
11 comment period of not greater than 30 days.

12 “(C) PUBLIC AWARENESS OF APPROVED
13 WAIVER.—A State that has been certified for a
14 comprehensive Medicaid waiver shall conduct an
15 outreach and education campaign to ensure
16 that health care providers and eligible individ-
17 uals within the State are provided with ade-
18 quate notice regarding the methods and criteria
19 through which the State intends to provide
20 medical assistance under the waiver.

21 “(9) DEFINITIONS.—In this subsection:

22 “(A) AVERAGE MONTHLY UNEMPLOYMENT
23 RATE.—The term ‘average monthly unemploy-
24 ment rate’ means the average of the monthly
25 number unemployed in the State, divided by the

average of the monthly civilian labor force in the State, seasonally adjusted, as determined based on the most recent monthly publications of the Bureau of Labor Statistics of the Department of Labor.

“(B) ELIGIBLE INDIVIDUAL.—The term ‘eligible individual’ means, for each year during the waiver period—

“(i) any individual who, for such year, the State would otherwise be required to provide medical assistance to pursuant to—

“(I) section 1902(a)(10)(A)(i);

“(II) paragraphs (1) or (4) of section 1902(e);

“(III) section 1925; or

“(IV) section 1931;

“(ii) at the option of the State, any individual who, for such year, the State would otherwise provide child health assistance to under the State child health plan under title XXI; and

“(iii) at the option of the State, any individual who is not described in clause (i) or (ii) and who satisfies such income, re-

1 sources, health status, or other criteria as
 2 the State may establish.

3 “(C) MEDICAL ASSISTANCE.—The term
 4 ‘medical assistance’ means—

5 “(i) health care coverage (as deter-
 6 mined by the State); and

7 “(ii) rehabilitation and other services
 8 to help eligible individuals attain or retain
 9 capability for independence or self-care,
 10 such as home and community-based serv-
 11 ices.

12 “(D) STATE MEDICAID PROGRAM.—The
 13 term ‘State Medicaid program’ means the State
 14 program for medical assistance provided under
 15 a State plan under title XIX, including any
 16 waiver that has been approved with respect to
 17 a State plan prior to an application by the
 18 State for a comprehensive Medicaid waiver
 19 under this subsection.”.

20 **SEC. 1102. PHASED-IN ELIMINATION OF ALLOWABLE PRO-**
 21 **VIDER TAXES UNDER MEDICAID.**

22 (a) IN GENERAL.—Clause (ii) of section
 23 1903(w)(4)(C) of the Social Security Act (42 U.S.C.
 24 1396b(w)(4)(C)) is amended to read as follows:

1 “(ii) For purposes of clause (i), a determination
2 of the existence of an indirect guarantee shall be
3 made under paragraph (3)(i) of section 433.68(f) of
4 title 42, Code of Federal Regulations, as in effect on
5 November 1, 2006, except that—

6 “(I) for portions of fiscal years beginning
7 on or after January 1, 2008, and before Octo-
8 ber 1, 2011, ‘5.5 percent’ shall be substituted
9 for ‘6 percent’ each place it appears;

10 “(II) for fiscal years 2012 and 2013, the
11 percentage specified under such paragraph shall
12 apply;

13 “(III) for fiscal years 2014 through 2022,
14 the percentage determined under clause (iii) for
15 the fiscal year shall be substituted for ‘6 per-
16 cent’ each place it appears; and

17 “(IV) for fiscal year 2023 and each fiscal
18 year thereafter, ‘0 percent’ shall be substituted
19 for ‘6 percent’ each place it appears.

20 “(iii) For purposes of clause (ii)(III), the per-
21 centage determined under this clause shall be equal
22 to the percentage applicable under subclause (II) or
23 (III) of clause (ii) for the preceding fiscal year, re-
24 duced by 0.6 percentage points.”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) shall take effect on October 1, 2013.

3 **TITLE II—MEDICARE**
 4 **Subtitle A—Medicare Total Health**
 5 **Program; Medicare Fee-for-**
 6 **Service Program Reforms; Re-**
 7 **ports**

8 **SEC. 2000. SHORT TITLE; PURPOSE.**

9 (a) SHORT TITLE.—This subtitle may be cited as the
 10 “Medicare Total Health Act of 2012”.

11 (b) PURPOSE.—The purpose of this subtitle is to
 12 amend title XVIII of the Social Security Act to improve
 13 the sustainability of the Medicare program by establishing
 14 a Total Health system, reforming the Medicare fee-for-
 15 service program, and for other purposes.

16 **PART I—MEDICARE TOTAL HEALTH PROGRAM**

17 **SEC. 2001. ESTABLISHMENT OF MEDICARE TOTAL HEALTH**
 18 **PROGRAM.**

19 (a) SUNSET OF MEDICARE ADVANTAGE PLANS.—
 20 Section 1851(a)(1) of the Social Security Act (42 U.S.C.
 21 1395w–21(a)(1)), in the matter preceding subparagraph
 22 (A), is amended by striking “Subject to” and inserting
 23 “For plan years beginning prior to January 1, 2017, and
 24 subject to”.

1 (b) ESTABLISHMENT.—Part C of title XVIII of the
 2 Social Security Act (42 U.S.C. 1395w–21 et seq.) is
 3 amended—

4 (1) in the part heading, by striking
 5 “**MEDICARE+CHOICE PROGRAM**” and inserting
 6 “**MEDICARE ADVANTAGE PROGRAM; MEDICARE**
 7 **TOTAL HEALTH PROGRAM**”;

8 (2) by inserting before section 1851 the fol-
 9 lowing:
 10 “Subpart 1—Medicare Advantage Program”; and

11 (3) by adding at the end the following new sub-
 12 part:

13 “Subpart 2—Medicare Total Health Program
 14 “ELIGIBILITY, ENROLLMENT, AND INFORMATION
 15 “SEC. 1860C–1. (a) ELIGIBILITY.—

16 “(1) IN GENERAL.—Notwithstanding section
 17 1851(a)(1) and subject to the succeeding provisions
 18 of this subpart, each Total Health eligible individual
 19 (as defined in paragraph (3)) may elect to receive
 20 benefits under this title—

21 “(A) through the original medicare fee-for-
 22 service program under parts A and B, including
 23 the option to elect qualified prescription drug
 24 coverage in accordance with section 1860D–1;
 25 or

1 “(B) through enrollment in a Total Health
2 plan under this subpart.

3 “(2) COVERAGE FIRST EFFECTIVE JANUARY 1,
4 2017.—Coverage under the Medicare Total Health
5 program shall first be effective on January 1, 2017.

6 “(3) TOTAL HEALTH ELIGIBLE INDIVIDUAL.—
7 For purposes of this subpart, the term ‘Total Health
8 eligible individual’ means an individual who is enti-
9 tled to benefits under part A and enrolled under
10 part B who resides in a Total Health region.

11 “(4) TYPES OF TOTAL HEALTH PLANS THAT
12 MAY BE AVAILABLE.—A Total Health plan may be
13 any of the types of plans of health insurance de-
14 scribed in section 1851(a)(2)(A), including a plan
15 for special needs individuals described in clause (ii)
16 of such section.

17 “(b) ENROLLMENT PROCESS FOR TOTAL HEALTH
18 PLANS.—

19 “(1) ESTABLISHMENT OF PROCESS.—

20 “(A) IN GENERAL.—The Secretary shall
21 establish a process for the enrollment,
22 disenrollment, termination, and change of en-
23 rollment of Total Health eligible individuals in
24 Total Health plans in a manner similar to (and

1 coordinated with) the process established under
2 section 1860D–1(b)(1).

3 “(B) REQUIREMENTS.—Except as other-
4 wise provided in this subsection, the process es-
5 tablished under subparagraph (A) shall include
6 a residency requirement similar to the residency
7 requirement described in section 1851(b)(1)
8 and shall take into account the process for exer-
9 cising choice described in section 1851(c).

10 “(2) INITIAL ENROLLMENT PERIOD.—

11 “(A) PROGRAM INITIATION.—In the case
12 of an individual who is a Total Health eligible
13 individual as of November 15, 2016, there shall
14 be an initial enrollment period beginning on Oc-
15 tober 15, 2016, and ending on December 7,
16 2016.

17 “(B) CONTINUING PERIODS.—In the case
18 of an individual who first becomes a Total
19 Health eligible individual after November 15,
20 2016, there shall be an initial enrollment period
21 which is the same as the period under section
22 1851(e)(1).

23 “(3) ANNUAL, COORDINATED ELECTION PE-
24 RIOD.—

1 “(A) IN GENERAL.—As part of the process
 2 established under paragraph (1), each indi-
 3 vidual who is eligible to make an election under
 4 this section may change such election during an
 5 annual, coordinated election period.

6 “(B) ANNUAL, COORDINATED ELECTION
 7 PERIOD.—For purposes of this section, the
 8 term ‘annual, coordinated election period’
 9 means, with respect to 2017 and succeeding
 10 years, the period beginning on October 15 and
 11 ending on December 7 of the year before such
 12 year.

13 “(4) SPECIAL ENROLLMENT PERIODS.—The
 14 Secretary shall establish special enrollment periods
 15 that are similar to the special enrollment periods es-
 16 tablished under section 1851(e)(4).

17 “(5) SPECIAL RULE.—

18 “(A) IN GENERAL.—Notwithstanding any
 19 other provision of law, the process established
 20 under paragraph (1) shall include, in the case
 21 of a Total Health eligible individual who has
 22 failed to enroll in either the original medicare
 23 fee-for-service program option or a Total
 24 Health plan prior to the beginning of a plan
 25 year (including a full-benefit dual eligible indi-

1 vidual (as defined in section 1935(c)(6))), for
2 the enrollment in a Total Health plan with a
3 monthly beneficiary premium under section
4 1860C–7(a) (taking into account any adjust-
5 ment under subparagraph (B) or (C) of section
6 1860C–7(a)(2) and without regard to any ad-
7 justment under subparagraph (D) or (E) of
8 such section) that does not exceed the base ben-
9 eficiary premium computed under section
10 1860C–7(a)(1).

11 “(B) SELECTION OF PLAN BY THE SEC-
12 RETARY.—In selecting a plan for the enrollment
13 of a Total Health eligible individual under sub-
14 paragraph (A), the Secretary shall first attempt
15 to identify the Total Health plan in which the
16 cost-sharing and health benefits are most simi-
17 lar to the coverage the individual had in the
18 preceding plan year. If there is more than one
19 such plan available, the Secretary shall enroll
20 such an individual on a random basis among all
21 such plans in the Total Health region. Nothing
22 in the previous sentence shall prevent such an
23 individual from declining or changing such en-
24 rollment.

1 “(C) INDIVIDUALS WHO ARE NOT TOTAL
 2 HEALTH ELIGIBLE INDIVIDUALS.—The Sec-
 3 retary shall establish procedures under which
 4 individuals who are entitled to, or enrolled for,
 5 coverage under part A or enrolled for coverage
 6 under part B (but not both), may continue to
 7 receive benefits with deductible and coinsurance
 8 amounts comparable to the benefits, deductible,
 9 and coinsurance amounts they would have re-
 10 ceived if this subpart had not been enacted.

11 “(c) PROVIDING INFORMATION TO BENE-
 12 FICIARIES.—

13 “(1) IN GENERAL.—The Secretary shall con-
 14 duct activities that are designed to broadly dissemi-
 15 nate information to Total Health eligible individuals
 16 (and prospective Total Health eligible individuals)
 17 regarding the coverage provided under this subpart.
 18 Such activities shall ensure that such information is
 19 first made available at least 30 days prior to the ini-
 20 tial enrollment period described in subsection
 21 (b)(2)(A).

22 “(2) ACTIVITIES.—The activities conducted
 23 under paragraph (1) shall be similar to the activities
 24 described in paragraph (2) of section 1860D–1(c)
 25 and contain comparative information similar to the

1 information described in paragraph (3) of such sec-
 2 tion.

3 “TOTAL HEALTH PLAN BENEFITS

4 “SEC. 1860C–2. (a) REQUIREMENTS.—

5 “(1) QUALIFIED TOTAL HEALTH BENEFITS.—

6 Each Total Health plan shall provide to individuals
 7 enrolled under this subpart, through providers and
 8 other persons that meet the applicable requirements
 9 of this title and part A of title XI, a qualified Total
 10 Health benefits package and qualified prescription
 11 drug coverage (described in section 1860D–2(a)).

12 “(2) DEFINITION OF QUALIFIED TOTAL
 13 HEALTH BENEFITS PACKAGE.—For purposes of this
 14 subpart, the term ‘qualified Total Health benefits
 15 package’ means either of the following:

16 “(A) STANDARD HEALTH BENEFITS COV-
 17 ERAGE WITH ACCESS TO NEGOTIATED
 18 PRICES.—Standard health benefits coverage (as
 19 defined in subsection (b)) and access to nego-
 20 tiated prices under subsection (d).

21 “(B) ALTERNATIVE TOTAL HEALTH BENE-
 22 FITS COVERAGE WITH AT LEAST ACTUARIALLY
 23 EQUIVALENT BENEFITS AND ACCESS TO NEO-
 24 TIATED PRICES.—Coverage of health benefits
 25 which meets the alternative health benefits cov-
 26 erage requirements under subsection (c) and ac-

cess to negotiated prices under subsection (d),
 but only if the benefit design of such coverage
 is approved by the Secretary, as provided under
 subsection (c).

“(3) PERMITTING SUPPLEMENTAL HEALTH
 BENEFITS COVERAGE.—

“(A) IN GENERAL.—Subject to subpara-
 graph (B), a qualified Total Health benefits
 package may include supplemental health bene-
 fits coverage consisting of either or both of the
 following:

“(i) CERTAIN REDUCTIONS IN COST-
 SHARING.—

“(I) IN GENERAL.—A reduction
 in the annual deductible or a reduc-
 tion in the coinsurance percentage, or
 any combination thereof, insofar as
 such a reduction or increase increases
 the actuarial value of benefits above
 the actuarial value of a basic Total
 Health benefits package.

“(II) CONSTRUCTION.—Nothing
 in this clause shall be construed as af-
 fecting the application of subsection
 (c)(3).

1 “(ii) ADDITIONAL BENEFITS.—Cov-
 2 erage of any health care item or service
 3 that is not covered under the original
 4 medicare fee-for-service program option or
 5 that is eligible for coverage under part D,
 6 subject to the approval of the Secretary.

7 “(B) REQUIREMENT FOR AT LEAST ONE
 8 BASIC BENEFITS PLAN.—A Total Health spon-
 9 sor may not offer a Total Health plan that pro-
 10 vides supplemental health benefits coverage
 11 pursuant to subparagraph (A) in an area unless
 12 the sponsor also offers a Total Health plan in
 13 the area that only provides a basic Total Health
 14 benefits package.

15 “(4) BASIC TOTAL HEALTH BENEFITS PACK-
 16 AGE.—For purposes of this subpart, the term ‘basic
 17 Total Health benefits package’ means either of the
 18 following:

19 “(A) Coverage that meets the requirements
 20 of paragraph (2)(A).

21 “(B) Coverage that meets the requirements
 22 of paragraph (2)(B) but does not have any sup-
 23 plemental health benefits coverage described in
 24 paragraph (3)(A).

1 “(5) APPLICATION OF SECONDARY PAYER PRO-
 2 VISIONS.—The provisions of section 1852(a)(4) shall
 3 apply under this subpart in the same manner as
 4 such provisions applied to a Medicare Advantage
 5 plan.

6 “(6) CONSTRUCTION.—Nothing in this sub-
 7 section shall be construed as changing the computa-
 8 tion of incurred costs under subsection (b)(3).

9 “(b) STANDARD HEALTH BENEFITS COVERAGE.—
 10 For purposes of this subpart, the term ‘standard health
 11 benefits coverage’ means coverage of benefits under the
 12 original medicare fee-for-service program option (as de-
 13 fined in section 1852(a)(1)(B)), including the following re-
 14 quirements:

15 “(1) DEDUCTIBLE.—The coverage has an an-
 16 nual deductible that is equal to the amount of the
 17 unified deductible for the year under section 1899C.

18 “(2) 20 PERCENT COINSURANCE.—The cov-
 19 erage has coinsurance (for costs above the annual
 20 deductible specified in paragraph (1) and up to the
 21 first threshold annual out-of-pocket limit specified in
 22 paragraph (3)(B)(i)) that is—

23 “(A) equal to 20 percent; or

24 “(B) actuarially equivalent (using proc-
 25 esses and methods established by the Secretary)

1 to an average expected payment of 20 percent
 2 of such costs.

3 “(3) PROTECTION AGAINST HIGH OUT-OF-POCK-
 4 ET EXPENDITURES.—

5 “(A) IN GENERAL.—The coverage provides
 6 benefits, after the Total Health eligible indi-
 7 vidual has incurred costs (as described in sub-
 8 paragraph (C)) for health benefits in a year
 9 equal to—

10 “(i) the first threshold annual out-of-
 11 pocket limit specified in subparagraph
 12 (B)(i) for that year but less than the sec-
 13 ond threshold annual out-of-pocket limit
 14 specified in subparagraph (B)(ii) for that
 15 year, with coinsurance that is equal to 5
 16 percent; and

17 “(ii) the second threshold annual out-
 18 of-pocket limit specified in subparagraph
 19 (B)(ii) for that year, without coinsurance.

20 “(B) ANNUAL OUT-OF-POCKET LIMITS
 21 SPECIFIED.—For purposes of this subpart:

22 “(i) FIRST THRESHOLD ANNUAL OUT-
 23 OF-POCKET LIMIT SPECIFIED.—The ‘first
 24 threshold annual out-of-pocket limit’ speci-
 25 fied in this clause is equal to the first

1 threshold annual out-of-pocket limit for the
 2 year specified in section 1899B(b)(1).

3 “(ii) SECOND THRESHOLD ANNUAL
 4 OUT-OF-POCKET LIMIT SPECIFIED.—The
 5 ‘second threshold annual out-of-pocket
 6 limit’ specified in this clause is equal to the
 7 second threshold annual out-of-pocket limit
 8 for the year specified in section
 9 1899B(b)(2).

10 “(C) APPLICATION.—In applying subpara-
 11 graph (A), incurred costs shall only include
 12 costs incurred with respect to health benefits
 13 for the annual deductible described in para-
 14 graph (1) and for cost-sharing described in
 15 paragraph (2) or paragraph (3)(A)(i), or for
 16 benefits that would have otherwise been covered
 17 under the plan but for the exhaustion of those
 18 benefits. Incurred costs do not include any costs
 19 incurred for health benefits which are not in-
 20 cluded (or treated as being included) under the
 21 plan.

22 “(c) ALTERNATIVE TOTAL HEALTH BENEFITS COV-
 23 ERAGE REQUIREMENTS.—A Total Health plan may pro-
 24 vide a different benefit design from standard health bene-
 25 fits coverage so long as the Secretary determines that the

1 following requirements are met and the plan applies for,
 2 and receives, the approval of the Secretary for such benefit
 3 design:

4 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
 5 ALENT COVERAGE.—

6 “(A) ASSURING EQUIVALENT VALUE OF
 7 TOTAL COVERAGE.—The actuarial value of the
 8 total coverage is at least equal to the actuarial
 9 value of standard health benefits coverage.

10 “(B) ASSURING EQUIVALENT UNSUB-
 11 SIDIZED VALUE OF COVERAGE.—The unsub-
 12 sidized value of the coverage is at least equal to
 13 the unsubsidized value of standard health bene-
 14 fits coverage. For purposes of this subpara-
 15 graph, the unsubsidized value of coverage is the
 16 amount by which the actuarial value of the cov-
 17 erage exceeds the subsidy payments with re-
 18 spect to such coverage.

19 “(C) ASSURING STANDARD PAYMENT FOR
 20 COSTS BELOW FIRST THRESHOLD ANNUAL OUT-
 21 OF-POCKET LIMIT.—The coverage is designed,
 22 based upon an actuarially representative pat-
 23 tern of utilization, to provide for the payment,
 24 with respect to costs incurred up to the first
 25 threshold annual out-of-pocket limit specified in

1 subsection (b)(3)(B)(i), of an amount equal to
 2 at least the product of—

3 “(i) the amount by which the costs in-
 4 curred exceed the deductible described in
 5 subsection (b)(1) for the year; and

6 “(ii) 100 percent minus the coinsur-
 7 ance percentage specified in subsection
 8 (b)(2).

9 “(2) APPROVAL OF BENEFIT PACKAGE.—The
 10 benefit package is approved by the Secretary as con-
 11 taining a comparable range of benefits to standard
 12 health benefits coverage and meets such other re-
 13 quirements of this subpart as the Secretary may
 14 specify.

15 “(3) MAXIMUM REQUIRED DEDUCTIBLE.—The
 16 deductible under the coverage shall not exceed the
 17 deductible amount specified under subsection (b)(1)
 18 for the year.

19 “(4) SAME PROTECTION AGAINST HIGH OUT-OF-
 20 POCKET EXPENDITURES.—The coverage provides the
 21 coverage required under subsection (b)(3).

22 “(d) ACCESS TO NEGOTIATED PRICES.—

23 “(1) ACCESS.—

24 “(A) IN GENERAL.—Under a qualified
 25 Total Health benefits package offered by a

1 Total Health sponsor offering a Total Health
2 plan, the sponsor shall provide enrollees with
3 access to negotiated prices used for payment for
4 covered health benefits, regardless of the fact
5 that no benefits may be payable under the cov-
6 erage with respect to such benefits because of
7 the application of a deductible or other cost-
8 sharing.

9 “(B) NEGOTIATED PRICES.—For purposes
10 of this subpart, negotiated prices shall take into
11 account negotiated price concessions, such as
12 discounts, direct or indirect subsidies, rebates,
13 and direct or indirect remunerations, for cov-
14 ered health benefits.

15 “(2) AUDITS.—To protect against fraud and
16 abuse and to ensure proper disclosures and account-
17 ing under this part and in accordance with section
18 1857(d)(2)(B), the Secretary may conduct periodic
19 audits, directly or through contracts, of the financial
20 statements and records of Total Health sponsors
21 with respect to Total Health Plans.

22 “(3) APPLICATION OF GENERAL EXCLUSION
23 PROVISIONS.—

1 “(A) IN GENERAL.—A Total Health plan
2 may exclude from a qualified Total Health ben-
3 efits package any health care item or service—

4 “(i) for which payment would not be
5 made if section 1862(a) applied to this
6 subpart; or

7 “(ii) which is not prescribed in ac-
8 cordance with the Total Health plan or
9 this subpart.

10 “(B) RECONSIDERATION AND APPEAL.—
11 Any exclusion under subparagraph (A) is a de-
12 termination subject to reconsideration and ap-
13 peal under this subpart.

14 “(e) SATISFACTION OF REQUIREMENTS.—A Total
15 Health plan satisfies the requirements of subsection (a)
16 in the same way a Medicare Advantage plan satisfied the
17 requirements of section 1852(a)(2).

18 “ACCESS TO A CHOICE OF QUALIFIED TOTAL HEALTH
19 BENEFITS PLANS

20 “SEC. 1860C–3. (a) ASSURING ACCESS TO A CHOICE
21 OF PLANS.—

22 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH
23 AREA.—The Secretary shall ensure that each Total
24 Health eligible individual has available, consistent
25 with paragraph (2), a choice of enrollment in at

7 “(b) FLEXIBILITY IN RISK ASSUMED.—In order to
8 ensure access pursuant to subsection (a) in an area the
9 Secretary may approve limited risk plans under section
10 1860C-5(g) for the area.

13 “SEC. 1860C-4. (a) DISSEMINATION OF INFORMA-
14 TION.—

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1 “(2) DISCLOSURE UPON REQUEST OF GENERAL
 2 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
 3 TION.—Upon request of a Total Health eligible indi-
 4 vidual who is eligible to enroll in a Total Health
 5 plan, the Total Health sponsor offering such plan
 6 shall provide information similar (as determined by
 7 the Secretary) to the information described in sec-
 8 tion 1852(c)(2) to such individual.

9 “(3) PROVISION OF SPECIFIC INFORMATION.—
 10 Each Total Health sponsor offering a Total Health
 11 plan shall have a mechanism for providing specific
 12 information on a timely basis to enrollees upon re-
 13 quest. Such mechanism shall include access to infor-
 14 mation through the use of a toll-free telephone num-
 15 ber and, upon request, the provision of such infor-
 16 mation in writing.

17 “(4) CLAIMS INFORMATION.—

18 “(A) IN GENERAL.—A Total Health spon-
 19 sor offering a Total Health plan must furnish
 20 to each enrollee in a form easily understandable
 21 to such enrollees—

22 “(i) an explanation of benefits (in ac-
 23 cordance with section 1806(a) or in a com-
 24 parable manner); and

1 “(ii) when Total Health benefits are
2 provided under this subpart, a notice of
3 the benefits in relation to—

4 “(I) the deductible described in
5 paragraph (1) of section 1860C–2(b)
6 for the current year; and

7 “(II) the annual out-of-pocket
8 limits under paragraph (3) of such
9 section for the current year.

10 “(B) TIMING OF NOTICES.—Notices under
11 subparagraph (A)(ii) need not be provided more
12 often than as specified by the Secretary.

13 “(b) ACCESS TO HEALTH CARE PROVIDERS.—

14 “(1) ASSURING PROVIDER ACCESS.—

15 “(A) DISCOUNTS ALLOWED FOR NETWORK
16 PROVIDERS.—For health benefits furnished
17 through in-network providers, a Total Health
18 plan may reduce coinsurance or copayments for
19 Total Health eligible individuals enrolled in the
20 plan below the level otherwise required. In no
21 case shall such a reduction result in an increase
22 in payments made by the Secretary under sec-
23 tion 1860C–8 to the Total Health sponsor of
24 the plan.

1 “(B) CONVENIENT ACCESS FOR NETWORK
2 PROVIDERS.—

3 “(i) IN GENERAL.—The Total Health
4 sponsor of the Total Health plan shall se-
5 cure the participation in its network of a
6 sufficient number of health care providers
7 that furnish health care items and services
8 under the plan directly to patients to en-
9 sure convenient access (consistent with
10 rules established by the Secretary).

11 “(ii) ADEQUATE EMERGENCY AC-
12 CESS.—Such rules shall include adequate
13 emergency access for enrollees.

14 “(C) LEVEL PLAYING FIELD.—Such a
15 sponsor shall permit enrollees to receive benefits
16 through any health care provider participating
17 in the program under this title with any dif-
18 ferential in charge paid by such enrollees.

19 “(2) USE OF STANDARDIZED TECHNOLOGY.—

20 “(A) IN GENERAL.—The Total Health
21 sponsor of a Total Health plan shall issue (and
22 reissue, as appropriate) such a card (or other
23 technology) that may be used by an enrollee to
24 assure access to health benefits under this sub-
25 part.

1 “(B) STANDARDS.—

2 “(i) IN GENERAL.—The Secretary
3 shall provide for the development, adop-
4 tion, or recognition of standards relating to
5 a standardized format for the card or
6 other technology required under subpara-
7 graph (A). Such standards shall be com-
8 patible with part C of title XI and may be
9 based on standards developed by an appro-
10 priate standard setting organization.

11 “(ii) CONSULTATION.—In developing
12 the standards under clause (i), the Sec-
13 retary shall consult with standard setting
14 organizations determined appropriate by
15 the Secretary.

16 “(iii) IMPLEMENTATION.—The Sec-
17 retary shall develop, adopt, or recognize
18 the standards under clause (i) by such date
19 as the Secretary determines shall be suffi-
20 cient to ensure that Total Health sponsors
21 utilize such standards beginning January
22 1, 2017.

23 “(c) COST AND UTILIZATION MANAGEMENT; QUAL-
24 ITY ASSURANCE; WELLNESS PROGRAM.—

1 “(1) IN GENERAL.—The Total Health sponsor
2 shall have in place, directly or through appropriate
3 arrangements, the following:

4 “(A) A cost-effective health benefits man-
5 agement program, including incentives to re-
6 duce costs when medically appropriate.

7 “(B) Quality assurance measures and sys-
8 tems to reduce errors and improve the use of
9 health benefits.

10 “(C) A wellness program described in
11 paragraph (2).

12 “(D) A program to control fraud, abuse,
13 and waste.

14 Nothing in this section shall be construed as impair-
15 ing a Total Health sponsor from utilizing cost man-
16 agement tools (including differential payments)
17 under all methods of operation.

18 “(2) WELLNESS PROGRAM.—

19 “(A) DESCRIPTION.—A wellness program
20 described in this paragraph is a program fo-
21 cused on health improvement, disease preven-
22 tion, and management of chronic conditions for
23 Total Health eligible individuals enrolled in a
24 plan under this part to optimize health out-
25 comes through improved use of health care

1 items and services and to reduce the risk of ad-
2 verse events.

3 “(B) ELEMENTS.—Such program may in-
4 clude elements that promote—

5 “(i) enhanced enrollee understanding
6 to promote the appropriate use of health
7 care items and services by enrollees and to
8 reduce the risk of potential adverse events
9 and to improve health outcomes through
10 beneficiary education, counseling, and
11 other appropriate means;

12 “(ii) increased enrollee adherence with
13 recommended regimens through compliance
14 programs and other appropriate means;
15 and

16 “(iii) detection of adverse events and
17 patterns of overuse and underuse of health
18 care items and services.

19 “(C) ASSESSMENT.—The Total Health
20 sponsor shall have in place a process to assess,
21 at least on a quarterly basis, the health benefits
22 use of individuals who are not enrolled in the
23 wellness program.

1 “(D) WELLNESS PROGRAM ENROLL-
2 MENT.—The Total Health sponsor shall have in
3 place a process to—

4 “(i) subject to clause (ii), automati-
5 cally enroll plan enrollees in the wellness
6 program required under this subsection;
7 and

8 “(ii) permit plan enrolles to opt-out of
9 enrollment in the wellness program.

10 “(E) DEVELOPMENT OF PROGRAM IN CO-
11 OPERATION WITH PHYSICIANS.—Such program
12 shall be developed in cooperation with physi-
13 cians.

14 “(F) COORDINATION WITH CARE MANAGE-
15 MENT PLANS.—The Secretary shall establish
16 guidelines for the coordination of any wellness
17 program under this paragraph with respect to
18 a targeted beneficiary described in section
19 1860D–4(c)(2)(A)(i) (applied by substituting
20 ‘Total Health eligible individual’ for ‘part D eli-
21 gible individual’) with any care management
22 plan established with respect to such beneficiary
23 under a chronic care improvement program
24 under section 1807.

1 “(G) CONSIDERATIONS IN PROVIDER
2 FEES.—The Total Health sponsor of a Total
3 Health plan shall take into account, in estab-
4 lishing fees for entities providing services under
5 such plan, the resources used, and time re-
6 quired to, implement the wellness program
7 under this paragraph. Each such sponsor shall
8 disclose to the Secretary upon request the
9 amount of any such fees.

10 “(d) CONSUMER SATISFACTION SURVEYS.—In order
11 to provide for comparative information under section
12 1860C–1(c), the Secretary shall conduct consumer satis-
13 faction surveys with respect to Total Health sponsors and
14 Total Health plans in a manner similar to the manner
15 such surveys were conducted for MA organizations and
16 MA plans under subpart 1.

17 “(e) GRIEVANCE MECHANISM.—Each Total Health
18 sponsor shall provide meaningful procedures for hearing
19 and resolving grievances between the sponsor (including
20 any entity or individual through which the sponsor pro-
21 vides covered benefits) and enrollees with Total Health
22 plans of the sponsor under this part in accordance with
23 section 1852(f).

24 “(f) COVERAGE DETERMINATIONS AND RECONSID-
25 ERATIONS.—A Total Health sponsor shall meet the re-

1 requirements of paragraphs (1) through (3) of section
2 1852(g) with respect to covered benefits under the Total
3 Health plan offered by the sponsor under this subpart in
4 the same manner as such requirements applied to an MA
5 organization with respect to covered benefits under an MA
6 plan offered by the organization under subpart 1.

7 “(g) APPEALS.—A Total Health sponsor shall meet
8 the requirements of paragraphs (4) and (5) of section
9 1852(g) with respect to benefits in a manner similar (as
10 determined by the Secretary) to the manner such require-
11 ments applied to an MA organization with respect to bene-
12 fits under the original medicare fee-for-service program
13 option under an MA plan. In applying this subsection, only
14 the Total Health eligible individual shall be entitled to
15 bring such an appeal.

16 “(h) PRIVACY, CONFIDENTIALITY, AND ACCURACY
17 OF ENROLLEE RECORDS.—The provisions of section
18 1852(h) shall apply to a Total Health sponsor and Total
19 Health plan in the same manner as such provisions ap-
20 plied to an MA organization and an MA plan.

21 “(i) TREATMENT OF ACCREDITATION.—Subpara-
22 graph (A) of section 1852(e)(4) (relating to treatment of
23 accreditation) shall apply to a Total Health sponsor under
24 this part in the same manner as such subparagraph ap-
25 plied to an MA organization.

1 “(j) REQUIREMENTS WITH RESPECT TO SALES AND
 2 MARKETING ACTIVITIES.—The following provisions shall
 3 apply to a Total Health sponsor (and the agents, brokers,
 4 and other third parties representing such sponsor) in the
 5 same manner as such provisions applied to a Medicare Ad-
 6 vantage organization (and the agents, brokers, and other
 7 third parties representing such organization):

8 “(1) The prohibition under section
 9 1851(h)(4)(C) on conducting activities described in
 10 section 1851(j)(1).

11 “(2) The requirement under section
 12 1851(h)(4)(D) to conduct activities described in
 13 paragraph (2) of section 1851(j) in accordance with
 14 the limitations established under such section.

15 “(3) The inclusion of the plan type in the plan
 16 name under section 1851(h)(6).

17 “(4) The requirements regarding the appoint-
 18 ment of agents and brokers and compliance with
 19 State information requests under subparagraphs (A)
 20 and (B), respectively, of section 1851(h)(7).

21 “TOTAL HEALTH REGIONS; SUBMISSION OF BIDS; TOTAL
 22 HEALTH PLAN APPROVAL

23 “SEC. 1860C–5. (a) ESTABLISHMENT OF TOTAL
 24 HEALTH REGIONS; SERVICE AREAS.—

25 “(1) COVERAGE OF ENTIRE TOTAL HEALTH RE-
 26 GION.—

1 “(A) IN GENERAL.—The service area for a
 2 Total Health plan shall consist of an entire
 3 Total Health region established under para-
 4 graph (2).

5 “(B) NO USE OF SEGMENTS OF SERVICE
 6 AREAS.—In no case may a Total Health plan
 7 serve only segments of the service area.

8 “(2) ESTABLISHMENT OF TOTAL HEALTH RE-
 9 GIONS.—

10 “(A) IN GENERAL.—The Secretary shall
 11 establish, and may revise, Total Health regions
 12 in accordance with the requirements of this
 13 paragraph.

14 “(B) REGIONS TO BE LARGER THAN A SIN-
 15 GLE COUNTY.—Total Health regions shall in-
 16 clude more than one county.

17 “(C) REGIONS WITHIN MSAS.—Among
 18 counties in a metropolitan statistical area, a
 19 Total Health region shall include all of the
 20 counties located in the same State in that met-
 21 ropolitan statistical area.

22 “(D) REGIONS OUTSIDE MSAS.—Among
 23 counties outside a metropolitan statistical area,
 24 a Total Health region shall include all of the
 25 counties in the same State that the Secretary

1 determines are accurate reflections of health
 2 care market areas, such as health service areas.

3 “(E) AUTHORITY FOR TERRITORIES.—The
 4 Secretary shall establish, and may revise, Total
 5 Health regions for areas in States that are not
 6 within the 50 States or the District of Colum-
 7 bia.

8 “(3) NATIONAL PLAN.—Nothing in this sub-
 9 section shall be construed as preventing a Total
 10 Health plan from being offered in more than one
 11 Total Health region (including all Total Health re-
 12 gions).

13 “(b) SUBMISSION OF BIDS, PREMIUMS, AND RE-
 14 LATED INFORMATION.—

15 “(1) IN GENERAL.—A Total Health sponsor
 16 shall submit to the Secretary information described
 17 in paragraph (2) with respect to each Total Health
 18 plan it offers. Such information shall be submitted
 19 at the same time and in a similar manner to the
 20 manner in which information described in paragraph
 21 (6) of section 1854(a) was submitted by an MA or-
 22 ganization under paragraph (1) of such section.

23 “(2) INFORMATION DESCRIBED.—The informa-
 24 tion described in this paragraph is information on
 25 the following:

1 “(A) BENEFITS PACKAGE PROVIDED.—The
 2 qualified Total Health benefits package pro-
 3 vided under the plan, including the deductible
 4 and other cost-sharing.

5 “(B) ACTUARIAL VALUE.—The actuarial
 6 value of the qualified Total Health benefits
 7 package in the Total Health region for a Total
 8 Health eligible individual with a national aver-
 9 age risk profile for the factors described in sec-
 10 tion 1860C–8(b)(1)(A) (as specified by the Sec-
 11 retary).

12 “(C) BID.—Information on the bid, includ-
 13 ing an actuarial certification of—

14 “(i) the basis for the actuarial value
 15 described in subparagraph (B) assumed in
 16 such bid;

17 “(ii) the portion of such bid attrib-
 18 utable to a basic Total Health benefits
 19 package and, if applicable, the portion of
 20 such bid attributable to supplemental bene-
 21 fits; and

22 “(iii) administrative expenses assumed
 23 in the bid.

24 “(D) SERVICE AREA.—The service area for
 25 the plan (as described in subsection (a)(1)).

1 “(E) LEVEL OF RISK ASSUMED.—Whether
 2 the Total Health sponsor requires a modifica-
 3 tion of risk level and, if so, the extent of such
 4 modification. Any such modification shall apply
 5 with respect to all Total Health plans offered
 6 by a Total Health sponsor in a Total Health re-
 7 gion.

8 “(F) ADDITIONAL INFORMATION.—Such
 9 other information as the Secretary may require
 10 to carry out this subpart.

11 “(3) PAPERWORK REDUCTION FOR OFFERING
 12 OF TOTAL HEALTH PLANS NATIONALLY OR IN
 13 MULTI-REGION AREAS.—The Secretary shall estab-
 14 lish requirements for the submission of information
 15 under this subsection in a manner that promotes the
 16 offering of such plans in more than one Total
 17 Health region (including all regions) through the fil-
 18 ing of consolidated information.

19 “(c) MEDICARE FEE-FOR-SERVICE BID.—For pur-
 20 poses of this subpart, the bid for benefits under the origi-
 21 nal medicare fee-for-service program option (as defined in
 22 section 1852(a)(1)(B)) is the dollar amount of the actu-
 23 arial valuation of the benefits under that option for each
 24 Total Health region (as determined and submitted by the
 25 Chief Actuary of the Centers for Medicare & Medicaid

1 Services using the same processes used to value Total
 2 Health plans under subsection (d)).

3 “(d) ACTUARIAL VALUATION.—

4 “(1) PROCESSES.—For purposes of this sub-
 5 part, the Secretary shall establish processes and
 6 methods for determining the actuarial valuation of a
 7 Total Health benefits package, including—

8 “(A) an actuarial valuation of the benefits
 9 under the original medicare fee-for-service pro-
 10 gram option (as defined in section
 11 1852(a)(1)(B)) in each service area;

12 “(B) actuarial valuations relating to the
 13 qualified Total Health benefits package under
 14 section 1860C–2(a)(1);

15 “(C) the use of generally accepted actu-
 16 arial principles and methodologies; and

17 “(D) applying the same methodology for
 18 determinations of actuarial valuations under
 19 subparagraphs (A) and (B).

20 “(2) ACCOUNTING FOR UTILIZATION.—Such
 21 processes and methods for determining actuarial
 22 valuation shall take into account the effect that pro-
 23 viding a qualified Total Health benefits package
 24 (rather than benefits under the original medicare

1 fee-for-service program option) has on the utilization
 2 of health care items and services.

3 “(3) RESPONSIBILITIES.—

4 “(A) PLAN RESPONSIBILITIES.—Total
 5 Health sponsors are responsible for the prepa-
 6 ration and submission of actuarial valuations
 7 required under this subpart for the Total
 8 Health plans offered by the sponsor.

9 “(B) USE OF OUTSIDE ACTUARIES.—

10 Under the processes and methods established
 11 under paragraph (1), Total Health sponsors of-
 12 fering a Total Health benefits package may use
 13 actuarial opinions certified by independent,
 14 qualified actuaries to establish actuarial values.

15 “(e) REVIEW OF INFORMATION AND NEGOTIA-
 16 TION.—

17 “(1) REVIEW OF INFORMATION.—The Secretary
 18 shall review the information submitted under sub-
 19 section (b) for the purpose of conducting negotia-
 20 tions under paragraph (2).

21 “(2) NEGOTIATION REGARDING TERMS AND
 22 CONDITIONS.—Subject to subsection (i), in exer-
 23 cising the authority under paragraph (1), the Sec-
 24 retary—

1 “(A) has the authority to negotiate the
 2 terms and conditions of the proposed bid sub-
 3 mitted and other terms and conditions of a pro-
 4 posed plan; and

5 “(B) has authority similar to the authority
 6 of the Director of the Office of Personnel Man-
 7 agement with respect to health benefits plans
 8 under chapter 89 of title 5, United States Code.

9 “(3) REJECTION OF BIDS.—Paragraph (5)(C)
 10 of section 1854(a) shall apply with respect to bids
 11 submitted by a Total Health sponsor under sub-
 12 section (b) in the same manner as such paragraph
 13 applied to bids submitted by an MA organization
 14 under such section 1854(a).

15 “(f) APPROVAL OF PROPOSED PLANS.—

16 “(1) IN GENERAL.—After review and negotia-
 17 tion under subsection (e), the Secretary shall ap-
 18 prove or disapprove the Total Health plan.

19 “(2) REQUIREMENTS FOR APPROVAL.—The
 20 Secretary may approve a Total Health plan only if
 21 the Secretary determines the following requirements
 22 are met:

23 “(A) COMPLIANCE WITH REQUIRE-
 24 MENTS.—The plan and the Total Health spon-
 25 sor offering the plan comply with the require-

ments under this subpart, including the provision of a qualified Total Health benefits package.

“(B) ACTUARIAL DETERMINATIONS.—The plan and Total Health sponsor offering the plan meet the requirements under this subpart relating to actuarial determinations, including such requirements under section 1860C–2(c).

“(C) APPLICATION OF FEHBP STANDARD.—

“(i) IN GENERAL.—The portion of the bid submitted under subsection (b) that is attributable to basic health benefits coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for benefits provided under that plan.

“(ii) SUPPLEMENTAL COVERAGE.—The portion of the bid submitted under subsection (b) that is attributable to supplemental health benefits coverage pursuant to section 1860C–2(a)(3) is supported

by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for such coverage under the plan.

“(D) PLAN DESIGN.—The design of the plan and covered benefits under the plan are not likely to substantially discourage enrollment by certain Total Health eligible individuals in the plan.

“(g) APPLICATION OF LIMITED RISK PLANS.—

“(1) CONDITIONS FOR APPROVAL OF LIMITED RISK PLANS.—The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a Total Health region if the access requirements under section 1860C–3(a) would not be met for the region but for the approval of such a plan.

“(2) RULES.—The following rules shall apply with respect to the approval of a limited risk plan in a Total Health region:

“(A) LIMITED EXERCISE OF AUTHORITY.—Only the minimum number of such plans may be approved in order to meet the access requirements under section 1860C–3(a).

1 “(B) MAXIMIZING ASSUMPTION OF RISK.—

2 The Secretary shall provide priority in approval
3 for those plans bearing the highest level of risk
4 (as computed by the Secretary), but the Sec-
5 retary may take into account the level of the
6 bids submitted by such plans.

7 “(C) NO FULL UNDERWRITING FOR LIM-

8 ITED RISK PLANS.—In no case may the Sec-
9 retary approve a limited risk plan under which
10 the modification of risk level provides for no (or
11 a de minimis) level of financial risk.

12 “(3) ACCEPTANCE OF ALL FULL RISK CON-

13 TRACTS.—There shall be no limit on the number of
14 full risk plans that are approved under subsection
15 (e).

16 “(4) RISK-PLANS DEFINED.—For purposes of
17 this subsection:

18 “(A) LIMITED RISK PLAN.—The term ‘lim-

19 ited risk plan’ means a Total Health plan that
20 provides a basic Total Health benefits package
21 and for which the Total Health sponsor in-
22 cludes a modification of risk level described in
23 subparagraph (E) of subsection (b)(2) in the
24 bid submitted for the plan under such sub-
25 section.

1 “(B) FULL RISK PLAN.—The term ‘full
2 risk plan’ means a Total Health plan that is
3 not a limited risk plan.

4 “(h) ANNUAL REPORT ON USE OF LIMITED RISK
5 PLANS.—The Secretary shall submit to Congress an an-
6 nual report that describes instances in which limited risk
7 plans were approved under this section. The Secretary
8 shall include in such report such recommendations as may
9 be appropriate to limit the need for the provision of such
10 plans and to maximize the assumption of financial risk
11 under such subsection.

12 “(i) NONINTERFERENCE.—In order to promote com-
13 petition under this part and in carrying out this part, the
14 Secretary—

15 “(1) may not interfere with the negotiations be-
16 tween physicians or other health professionals, pro-
17 viders, suppliers, drug manufacturers, pharmacies,
18 and Total Health sponsors; and

19 “(2) may not require a particular benefit design
20 or formulary, or institute a price structure for the
21 reimbursement of covered items and services.

22 “REQUIREMENTS FOR AND CONTRACTS WITH TOTAL
23 HEALTH SPONSORS

24 “SEC. 1860C–6. (a) GENERAL REQUIREMENTS.—
25 Each sponsor of a Total Health plan shall meet the fol-
26 lowing requirements:

1 “(1) LICENSURE.—Subject to subsection (c),
 2 the sponsor is organized and licensed under State
 3 law as a risk-bearing entity eligible to offer health
 4 insurance or health benefits coverage in each State
 5 in which it offers a Total Health plan.

6 “(2) ASSUMPTION OF FINANCIAL RISK FOR UN-
 7 SUBSIDIZED COVERAGE.—

8 “(A) IN GENERAL.—Subject to subpara-
 9 graph (B), to the extent that the entity is at
 10 risk the entity assumes financial risk on a pro-
 11 spective basis for benefits that it offers under
 12 a Total Health plan.

13 “(B) REINSURANCE PERMITTED.—The
 14 plan sponsor may obtain insurance or make
 15 other arrangements for the cost of coverage
 16 provided to any enrollee to the extent that the
 17 sponsor is at risk for providing such coverage.

18 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—
 19 In the case of a Total Health sponsor that is not de-
 20 scribed in paragraph (1) and for which a waiver has
 21 been approved under subsection (c), such sponsor
 22 shall meet solvency standards established by the Sec-
 23 retary under subsection (d).

24 “(b) CONTRACT REQUIREMENTS.—

1 “(1) IN GENERAL.—The Secretary shall not
2 permit the enrollment under section 1860C–1 in a
3 Total Health plan offered by a Total Health sponsor
4 under this subpart, and the sponsor shall not be eli-
5 gible for payments under section 1860C–8, unless
6 the Secretary has entered into a contract under this
7 subsection with the sponsor with respect to the of-
8 fering of such plan. Such a contract with a sponsor
9 may cover more than one Total Health plan. Such
10 contract shall provide that the sponsor agrees to
11 comply with the applicable requirements and stand-
12 ards of this subpart and the terms and conditions of
13 payment as provided for in this subpart.

14 “(2) INCORPORATION OF CERTAIN MEDICARE
15 ADVANTAGE CONTRACT REQUIREMENTS.—Except as
16 otherwise provided, the following provisions of sec-
17 tion 1857 shall apply to contracts under this section
18 in the same manner as such provisions applied to
19 contracts under section 1857(a):

20 “(A) MINIMUM ENROLLMENT.—Para-
21 graphs (1) and (3) of section 1857(b), except
22 that—

23 “(i) the Secretary may increase the
24 minimum number of enrollees required

1 under such paragraph (1) as the Secretary
2 determines appropriate; and

3 “(ii) the requirement of such para-
4 graph (1) shall be waived during the first
5 contract year with respect to an organiza-
6 tion in a region.

7 “(B) CONTRACT PERIOD AND EFFECTIVE-
8 NESS.—Section 1857(c), except that in applying
9 paragraph (4)(B) of such section any reference
10 to payment amounts under section 1853 is
11 deemed a reference to payment amounts under
12 section 1860C–8.

13 “(C) PROTECTIONS AGAINST FRAUD AND
14 BENEFICIARY PROTECTIONS.—Section 1857(d).

15 “(D) ADDITIONAL CONTRACT TERMS.—
16 Section 1857(e); except that section 1857(e)(2)
17 shall apply as specified to Total Health spon-
18 sors and payments to a Total Health plan
19 under this subpart shall be treated as expendi-
20 tures made under this subpart. Notwith-
21 standing any other provision of law, information
22 provided to the Secretary under the application
23 of section 1857(e)(1) to contracts under this
24 section under the preceding sentence—

1 “(i) may be used for the purposes of
 2 carrying out this subpart, improving public
 3 health through research on the utilization,
 4 safety, effectiveness, quality, and efficiency
 5 of health care services (as the Secretary
 6 determines appropriate); and

7 “(ii) shall be made available to Con-
 8 gressional support agencies (in accordance
 9 with their obligations to support Congress
 10 as set out in their authorizing statutes) for
 11 the purposes of conducting Congressional
 12 oversight, monitoring, making rec-
 13 ommendations, and analysis of the pro-
 14 gram under this title.

15 “(E) INTERMEDIATE SANCTIONS.—Section
 16 1857(g) (other than paragraph (1)(F) of such
 17 section), except that in applying such section
 18 the reference in section 1857(g)(1)(B) to sec-
 19 tion 1854 is deemed a reference to this subpart.

20 “(F) PROCEDURES FOR TERMINATION.—
 21 Section 1857(h).

22 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
 23 PAND CHOICE.—

24 “(1) AUTHORIZING WAIVER.—

“(A) IN GENERAL.—In the case of an entity that seeks to offer a Total Health plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

“(B) APPLICATION OF REGIONAL PLAN WAIVER RULE.—In addition to the waiver available under subparagraph (A), the provisions of section 1858(d) shall apply to Total Health sponsors under this part in a manner similar to the manner in which such provisions applied to MA organizations.

“(2) GROUNDS FOR APPROVAL.—

“(A) IN GENERAL.—The grounds for approval under this paragraph are—

“(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2); and

1 “(ii) the application by a State of any
2 grounds other than those required under
3 Federal law.

4 “(B) SPECIAL RULES.—In applying sub-
5 paragraph (A)(i)—

6 “(i) the ground of approval described
7 in section 1855(a)(2)(B) is deemed to have
8 been met if the State does not have a li-
9 censing process in effect with respect to
10 the Total Health sponsor; and

11 “(ii) for plan years beginning before
12 January 1, 2019, if the State does have
13 such a licensing process in effect, such
14 ground for approval described in such sec-
15 tion is deemed to have been met upon sub-
16 mission of an application described in such
17 section.

18 “(3) APPLICATION OF WAIVER PROCEDURES.—
19 With respect to an application for a waiver (or a
20 waiver granted) under paragraph (1)(A) of this sub-
21 section, the provisions of subparagraphs (E), (F),
22 and (G) of section 1855(a)(2) shall apply, except
23 that clauses (i) and (ii) of such subparagraph (E)
24 shall not apply in the case of a State that does not

1 have a licensing process described in paragraph
 2 (2)(B)(i) in effect.

3 “(4) REFERENCES TO CERTAIN PROVISIONS.—

4 In applying provisions of section 1855(a)(2) under
 5 paragraphs (2) and (3) of this subsection to Total
 6 Health plans and Total Health sponsors—

7 “(A) any reference to a waiver application
 8 under section 1855 shall be treated as a ref-
 9 erence to a waiver application under paragraph
 10 (1)(A) of this subsection; and

11 “(B) any reference to solvency standards
 12 shall be treated as a reference to solvency
 13 standards established under subsection (d) of
 14 this section.

15 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
 16 ENTITIES.—

17 “(1) ESTABLISHMENT AND PUBLICATION.—The
 18 Secretary, in consultation with the National Associa-
 19 tion of Insurance Commissioners, shall establish and
 20 publish, by not later than January 1, 2016, financial
 21 solvency and capital adequacy standards for entities
 22 described in paragraph (2).

23 “(2) COMPLIANCE WITH STANDARDS.—A Total
 24 Health sponsor that is not licensed by a State under
 25 subsection (a)(1) and for which a waiver application

1 has been approved under subsection (c) shall meet
 2 solvency and capital adequacy standards established
 3 under paragraph (1). The Secretary shall establish
 4 certification procedures for such sponsors with re-
 5 spect to such solvency standards in the manner de-
 6 scribed in section 1855(c)(2).

7 “(e) LICENSURE DOES NOT SUBSTITUTE FOR OR
 8 CONSTITUTE CERTIFICATION.—The fact that a Total
 9 Health sponsor is licensed in accordance with subsection
 10 (a)(1) or has a waiver application approved under sub-
 11 section (c) does not deem the sponsor to meet other re-
 12 quirements imposed under this subpart for a sponsor.

13 “(f) PERIODIC REVIEW AND REVISION OF STAND-
 14 ARDS.—

15 “(1) IN GENERAL.—Subject to paragraph (2),
 16 the Secretary may periodically review the standards
 17 established under this section and, based on such re-
 18 view, may revise such standards if the Secretary de-
 19 termines such revision to be appropriate.

20 “(2) PROHIBITION OF MIDYEAR IMPLEMENTA-
 21 TION OF SIGNIFICANT NEW REGULATORY REQUIRE-
 22 MENTS.—The Secretary may not implement, other
 23 than at the beginning of a calendar year, regulations
 24 under this section that impose new, significant regu-

latory requirements on a Total Health sponsor or a
Total Health plan.

“(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES; RELATION TO STATE LAWS.—The provisions of sections 1854(g) and 1856(b)(3) shall apply with respect to Total Health sponsors and Total Health plans under this part in the same manner as such provisions applied to MA organizations and MA plans.

“TOTAL HEALTH PREMIUMS

“SEC. 1860C-7. (a) MONTHLY BENEFICIARY PREMIUM.—

“(1) BASE BENEFICIARY PREMIUM.—The base beneficiary premium under this paragraph for a Total Health plan for a month is equal to the product of—

“(A) 15 percent; and

“(B) an amount determined by the Secretary to be equal to the 40th percentile of the monthly standardized bid amounts (as defined in subsection (c), weighted under subsection (b), and adjusted under section 1860C-8(b)(2)) for the service area in which the plan is offered.

“(2) COMPUTATION OF MONTHLY BENEFICIARY PREMIUM.—

“(A) IN GENERAL.—The monthly beneficiary premium for a Total Health plan is the

base beneficiary premium computed under paragraph (1) as adjusted under this paragraph.

“(B) ADJUSTMENT TO REFLECT DIFFERENCE BETWEEN BID AND 40TH PERCENTILE OF THE MONTHLY STANDARDIZED BID AMOUNT.—

“(i) ABOVE 40TH PERCENTILE.—If the beneficiary enrolls in a plan with a monthly standardized bid amount that exceeds the 40th percentile (as determined under paragraph (1)(B)), the base beneficiary premium for the month shall be increased by the amount of such excess.

“(ii) BELOW 40TH PERCENTILE.—If the beneficiary enrolls in a plan with a monthly standardized bid amount that is less than the 40th percentile (as determined under paragraph (1)(B)), the base beneficiary premium for the month shall be decreased by the amount of such difference. Any reduction under the preceding sentence shall not result in a monthly beneficiary premium that is less than \$0.

“(C) INCREASE FOR SUPPLEMENTAL BENEFITS.—The base beneficiary premium shall be

1 increased by the portion of the Total Health ap-
 2 proved bid that is attributable to supplemental
 3 benefits.

4 “(D) INCREASE FOR LATE ENROLLMENT
 5 PENALTY.—The base beneficiary premium shall
 6 be increased by the amount of any late enroll-
 7 ment penalty under subsection (e).

8 “(E) INCREASE BASED ON INCOME.—The
 9 monthly beneficiary premium shall be increased
 10 pursuant to subsection (f).

11 “(F) UNIFORM PREMIUM.—Except as pro-
 12 vided in subparagraphs (D) and (E), the
 13 monthly beneficiary premium for a Total
 14 Health plan in a Total Health region is the
 15 same for all Total Health eligible individuals
 16 enrolled in the plan.

17 “(b) WEIGHTING OF BID AMOUNTS BASED ON EN-
 18 ROLLMENT.—

19 “(1) IN GENERAL.—For purposes of subsection
 20 (a)(1)(B), the weight for each plan in the service
 21 area shall be equal to the average number of Total
 22 Health eligible individuals enrolled in such plan in
 23 the reference month (as defined in section
 24 1858(f)(4)).

1 “(2) SPECIAL RULE FOR 2017.—For purposes of
 2 applying this paragraph for 2017, the Secretary
 3 shall establish procedures for determining the
 4 weighted average under paragraph (1) for 2016.

5 “(c) STANDARDIZED BID AMOUNT DEFINED.—For
 6 purposes of this subsection, the term ‘standardized bid
 7 amount’ means the following:

8 “(1) BASIC COVERAGE ONLY.—In the case of a
 9 Total Health plan that provides basic health benefits
 10 coverage, the Total Health approved bid (as defined
 11 in subsection (d)).

12 “(2) PLANS OFFERING SUPPLEMENTAL COV-
 13 ERAGE.—In the case of a Total Health plan that
 14 provides supplemental health benefits coverage, only
 15 the portion of the Total Health approved bid that is
 16 attributable to basic health benefits coverage.

17 “(d) TOTAL HEALTH APPROVED BID DEFINED.—
 18 For purposes of this subpart, the term ‘Total Health ap-
 19 proved bid’ means—

20 “(1) with respect to a Total Health plan, the
 21 bid amount approved for the plan under section
 22 1860C–5; and

23 “(2) with respect to the original medicare fee-
 24 for-service program option, the bid described in sec-
 25 tion 1860C–5(c).

1 “(e) LATE ENROLLMENT PENALTY.—The monthly
 2 beneficiary premium established under subsection (a) shall
 3 be subject to adjustment in the same manner as the part
 4 B monthly beneficiary premium computed under section
 5 1839 is subject to adjustment under subsection (b) of such
 6 section, except that, in applying the late enrollment pen-
 7 alty under such subsection, the initial enrollment period
 8 of the individual shall be the enrollment period under
 9 1860C–1(b)(2) instead of the initial enrollment period de-
 10 scribed in such section 1839(b).

11 “(f) INCREASE IN BASE BENEFICIARY PREMIUM
 12 BASED ON INCOME.—

13 “(1) IN GENERAL.—In the case of an individual
 14 whose modified adjusted gross income (as defined in
 15 paragraph (2)) exceeds the threshold amount appli-
 16 cable under paragraph (2) of section 1839(i) (includ-
 17 ing application of paragraph (5) of such section), the
 18 Secretary shall substitute the applicable percentage
 19 determined under paragraph (3)(C) of section
 20 1839(i) for the individual for the calendar year for
 21 the percentage described in subsection (a)(1)(A).

22 “(2) MODIFIED ADJUSTED GROSS INCOME.—
 23 For purposes of this subsection, the term ‘modified
 24 adjusted gross income’ has the meaning given such
 25 term in subparagraph (A) of section 1839(i)(4), de-

1 terminated for the taxable year applicable under sub-
2 paragraphs (B) and (C) of such section.

3 “(3) DETERMINATION BY COMMISSIONER OF
4 SOCIAL SECURITY.—The Commissioner of Social Se-
5 curity shall make any determination necessary to
6 carry out the income-related increase in the base
7 beneficiary premium under this subsection.

8 “(4) PROCEDURES TO ASSURE CORRECT IN-
9 COME-RELATED INCREASE IN BASE BENEFICIARY
10 PREMIUM.—

11 “(A) DISCLOSURE OF BASE BENEFICIARY
12 PREMIUM.—Not later than September 15 of
13 each year beginning with 2016, the Secretary
14 shall disclose to the Commissioner of Social Se-
15 curity the amount of the base beneficiary pre-
16 mium (as computed under subsection (a)(1))
17 for the purpose of carrying out the income-re-
18 lated increase in the base beneficiary premium
19 under this subsection with respect to the fol-
20 lowing year.

21 “(B) ADDITIONAL DISCLOSURE.—Not later
22 than October 15 of each year beginning with
23 2016, the Secretary shall disclose to the Com-
24 missioner of Social Security the following infor-
25 mation for the purpose of carrying out the in-

come-related increase in the base beneficiary premium under this subsection with respect to the following year:

“(i) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

“(ii) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

“(iii) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this subsection.

“PREMIUM AND COST-SHARING SUPPORT FOR TOTAL
HEALTH ELIGIBLE INDIVIDUALS

“SEC. 1860C–8. (a) DIRECT SUBSIDY PAYMENT.—

The Secretary shall provide for payment to a Total Health sponsor that offers a Total Health plan a direct subsidy for each Total Health eligible individual enrolled in a Total Health plan for a month equal to—

“(1) the amount of the plan’s standardized bid amount (as defined in section 1860C–7(c)), adjusted under subsection (b)(1), reduced by

1 “(2) the base beneficiary premium (as com-
 2 puted under paragraph (1) of section 1860C–7(a)
 3 and as adjusted under paragraph (2)(B) of such sec-
 4 tion).

5 “(b) ADJUSTMENTS RELATING TO BIDS.—

6 “(1) HEALTH STATUS RISK ADJUSTMENT.—

7 “(A) ESTABLISHMENT OF RISK ADJUS-
 8 TORS.—The Secretary shall establish an appro-
 9 priate methodology for adjusting the standard-
 10 ized bid amount under subsection (a)(1) to take
 11 into account variation in costs for health bene-
 12 fits coverage among Total Health plans based
 13 on the differences in actuarial risk of different
 14 enrollees being served. Any such risk adjust-
 15 ment shall be designed in a manner so as not
 16 to result in a change in the aggregate amounts
 17 payable to such plans under subsection (a) and
 18 through that portion of the monthly beneficiary
 19 Total Health premiums described in subsection
 20 (a)(2).

21 “(B) CONSIDERATIONS.—In establishing
 22 the methodology under subparagraph (A), the
 23 Secretary may take into account the similar
 24 methodologies used under section 1853(a)(3) to
 25 adjust payments to MA organizations for bene-

fits under the original medicare fee-for-service program option.

“(C) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Total Health sponsors to submit data regarding claims that can be linked at the individual level to data under this title and such other information as the Secretary determines necessary.

“(D) PUBLICATION.—At the time of publication of risk adjustment factors under section 1860D–15(c)(1)(D), the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

“(2) GEOGRAPHIC ADJUSTMENT.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of section 1860C–7(a)(1)(B), the Secretary shall establish an appropriate methodology for adjusting the amount determined under such section to take into account differences in prices for covered health benefits among Total Health regions.

“(B) DE MINIMIS RULE.—If the Secretary determines that the price variations described in subparagraph (A) among Total Health re-

1 gions are de minimis, the Secretary shall not
2 provide for adjustment under this paragraph.

3 “(C) BUDGET NEUTRAL ADJUSTMENT.—

4 Any adjustment under this paragraph shall be
5 applied in a manner so as to not result in a
6 change in the aggregate payments made under
7 this subpart that would have been made if the
8 Secretary had not applied such adjustment.

9 “(c) PAYMENT METHODS.—

10 “(1) IN GENERAL.—Payments under this sec-
11 tion shall be based on such a method as the Sec-
12 retary determines. The Secretary may establish a
13 payment method by which interim payments of
14 amounts under this section are made during a year
15 based on the Secretary’s best estimate of amounts
16 that will be payable after obtaining all of the infor-
17 mation.

18 “(2) REQUIREMENT FOR PROVISION OF INFOR-
19 MATION.—

20 “(A) REQUIREMENT.—Payments under
21 this section to a Total Health sponsor are con-
22 ditioned upon the furnishing to the Secretary,
23 in a form and manner specified by the Sec-
24 retary, of such information as may be required
25 to carry out this section.

1 “(B) RESTRICTION ON USE OF INFORMA-
 2 TION.—Information disclosed or obtained pur-
 3 suant to subparagraph (A) may be used by offi-
 4 cers, employees, and contractors of the Depart-
 5 ment of Health and Human Services only for
 6 the purposes of, and to the extent necessary in,
 7 carrying out this section.

8 “(3) SOURCE OF PAYMENTS.—Payments under
 9 this section shall be made from the Federal Hospital
 10 Insurance Trust Fund under section 1817 and the
 11 Federal Supplementary Medical Insurance Trust
 12 Fund under section 1841, in such proportion as the
 13 Secretary determines appropriate.

14 “(4) APPLICATION OF ENROLLEE ADJUST-
 15 MENT.—The provisions of section 1853(a)(2) shall
 16 apply to payments to Total Health sponsors under
 17 this section in the same manner as they applied to
 18 payments to MA organizations under section
 19 1853(a).

20 “(d) PLANS AT RISK FOR ENTIRE AMOUNT OF BEN-
 21 EFITS.—A Total Health sponsor that offers a plan under
 22 this subpart shall be at full financial risk for the provision
 23 of benefits under such plan.

24 “(e) DISCLOSURE OF INFORMATION.—

1 “(1) IN GENERAL.—Each contract under this
2 subpart shall provide that—

3 “(A) the Total Health sponsor offering a
4 Total Health plan shall provide the Secretary
5 with such information as the Secretary deter-
6 mines is necessary to carry out this section; and

7 “(B) the Secretary shall have the right in
8 accordance with section 1857(d)(2)(B) (as ap-
9 plied under section 1860C–6(b)(2)(C)) to in-
10 spect and audit any books and records of a
11 Total Health sponsor that pertain to the infor-
12 mation regarding costs provided to the Sec-
13 retary under subparagraph (A).

14 “(2) RESTRICTION ON USE OF INFORMATION.—
15 Information disclosed or obtained pursuant to the
16 provisions of this section may be used—

17 “(A) by officers, employees, and contrac-
18 tors of the Department of Health and Human
19 Services for the purposes of, and to the extent
20 necessary in—

21 “(i) carrying out this section; and

22 “(ii) conducting oversight, evaluation,
23 and enforcement under this title; and

24 “(B) by the Attorney General and the
25 Comptroller General of the United States for

1 the purposes of, and to the extent necessary in,
 2 carrying out health oversight activities.

3 “EXEMPTION FOR MSA PLANS

4 “SEC. 1860C–9. (a) IN GENERAL.—None of the pro-
 5 visions in this subpart shall apply to an MSA plan (as
 6 defined in section 1859(b)(3)) and an MSA plan may not
 7 be a Total Health plan.

8 “(b) CONTINUING AVAILABILITY.—Notwithstanding
 9 any other provision of law, the Secretary shall establish
 10 procedures under which—

11 “(1) MSA plans may continue to operate on
 12 and after January 1, 2017; and

13 “(2) individuals who would have been eligible to
 14 enroll in those plans prior to such date continue to
 15 be eligible to enroll in such a plan.

16 “SPECIAL RULES FOR EMPLOYER-SPONSORED PROGRAMS

17 “SEC. 1860C–10. (a) SUBSIDY PAYMENT.—

18 “(1) IN GENERAL.—The Secretary shall provide
 19 in accordance with this subsection for payment to
 20 the sponsor of a qualified retiree health benefits plan
 21 (as defined in paragraph (2)) of a special subsidy
 22 payment equal to the amount specified in paragraph
 23 (3) for each qualified covered retiree under the plan
 24 (as defined in paragraph (4)). This subsection con-
 25 stitutes budget authority in advance of appropria-
 26 tions Acts and represents the obligation of the Sec-

1 retary to provide for the payment of amounts pro-
2 vided under this section.

3 “(2) QUALIFIED RETIREE HEALTH BENEFITS
4 PLAN DEFINED.—For purposes of this subsection,
5 the term ‘qualified retiree health benefits plan’
6 means employment-based retiree health coverage (as
7 defined in subsection (c)(1)) if, with respect to a
8 Total Health eligible individual who is a participant
9 or beneficiary under such coverage, the following re-
10 quirements are met:

11 “(A) ATTESTATION OF ACTUARIAL
12 EQUIVALENCE TO STANDARD COVERAGE.—The
13 sponsor of the plan provides the Secretary, an-
14 nually or at such other time as the Secretary
15 may require, with an attestation that the actu-
16 arial value of health benefits coverage under the
17 plan (as determined using the processes and
18 methods described in section 1860C–5(d)) is at
19 least equal to the actuarial value of standard
20 health benefits coverage.

21 “(B) AUDITS.—The sponsor of the plan, or
22 an administrator of the plan designated by the
23 sponsor, shall maintain (and afford the Sec-
24 retary access to) such records as the Secretary
25 may require for purposes of audits and other

oversight activities necessary to ensure the adequacy of health benefits coverage and the accuracy of payments made under this section. The provisions of section 1860C–2(d)(2) shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of Total Health sponsors.

“(C) PROVISION OF DISCLOSURE REGARDING HEALTH BENEFITS COVERAGE.—

“(i) IN GENERAL.—Each entity that offers employment-based retiree health coverage shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and Total Health eligible individuals of whether the coverage meets the requirement of subparagraph (A) or whether such coverage is changed so it no longer meets such requirement.

“(ii) DISCLOSURE OF NON-QUALIFIED COVERAGE.—In the case of such coverage that does not meet such requirement, the disclosure to Total Health eligible individ-

uals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a Total Health plan.

“(iii) WAIVER OF REQUIREMENT.—In the case of a Total Health eligible individual who was enrolled in employment-based retiree health coverage which does not meet the requirement of subparagraph (A), the individual may apply to the Secretary to have such coverage treated as a qualified retiree health benefits plan if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

“(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

“(A) IN GENERAL.—For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree health benefits plan is, for the portion of the retiree’s gross

covered retiree plan-related health benefits costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered retiree plan-related health benefits costs.

“(B) COST THRESHOLD AND COST LIMIT APPLICABLE.—

“(i) IN GENERAL.—Subject to clause (ii)—

“(I) the cost threshold under this subparagraph is equal to \$250 for plan years that end in 2017; and

“(II) the cost limit under this subparagraph is equal to \$5,000 for plan years that end in 2017.

“(ii) INDEXING.—The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2017 shall be adjusted in the same manner as the unified deductible and the annual out-of-pocket limits,

1 respectively, are annually adjusted under
2 sections 1899B and 1899C.

3 “(C) DEFINITIONS.—For purposes of this
4 paragraph:

5 “(i) ALLOWABLE RETIREE COSTS.—
6 The term ‘allowable retiree costs’ means,
7 with respect to gross covered health bene-
8 fits costs under a qualified retiree health
9 benefits plan by a plan sponsor, the part of
10 such costs that are actually paid (net of
11 discounts, chargebacks, and average per-
12 centage rebates) by the sponsor or by or
13 on behalf of a qualifying covered retiree
14 under the plan.

15 “(ii) GROSS COVERED RETIREE PLAN-
16 RELATED HEALTH BENEFITS COSTS.—The
17 term ‘gross covered retiree plan-related
18 health benefits costs’ means, with respect
19 to a qualifying covered retiree enrolled in
20 a qualified retiree health benefits plan dur-
21 ing a coverage year, the costs incurred
22 under the plan, not including administra-
23 tive costs, but including costs directly re-
24 lated to the furnishing of health benefits
25 items and services during the year. Such

1 costs shall be determined whether they are
 2 paid by the retiree or under the plan.

3 “(iii) COVERAGE YEAR.—The term
 4 ‘coverage year’ has the meaning given such
 5 term in section 1860D–15(b)(4) (as ap-
 6 plied by substituting ‘covered health bene-
 7 fits’ for ‘covered part D drugs’).

8 “(4) QUALIFYING COVERED RETIREE DE-
 9 FINED.—For purposes of this subsection, the term
 10 ‘qualifying covered retiree’ means a Total Health eli-
 11 gible individual who is not enrolled in a Total Health
 12 plan but is covered under a qualified retiree health
 13 benefits plan.

14 “(5) PAYMENT METHODS, INCLUDING PROVI-
 15 SION OF NECESSARY INFORMATION.—The provisions
 16 of section 1860C–8(c) (including paragraph (2) of
 17 such section, relating to requirement for provision of
 18 information) shall apply to payments under this sub-
 19 section in a manner similar to the manner in which
 20 they apply to payments under section 1860C–8.

21 “(6) CONSTRUCTION.—Nothing in this sub-
 22 section shall be construed as—

23 “(A) precluding a Total Health eligible in-
 24 dividual who is covered under employment-

1 based retiree health coverage from enrolling in
2 a Total Health plan;

3 “(B) precluding such employment-based
4 retiree health coverage or an employer or other
5 person from paying all or any portion of any
6 premium required for coverage under a Total
7 Health plan on behalf of such an individual;

8 “(C) preventing such employment-based
9 retiree health coverage from providing cov-
10 erage—

11 “(i) that is better than standard
12 health benefits coverage to retirees who are
13 covered under a qualified retiree health
14 benefits plan; or

15 “(ii) that is supplemental to the bene-
16 fits provided under a Total Health plan,
17 including benefits to retirees who are not
18 covered under a qualified retiree health
19 benefits plan but who are enrolled in such
20 a Total Health plan; or

21 “(D) preventing employers from providing
22 for flexibility in benefit design and provider ac-
23 cess provisions, without regard to the require-
24 ments for basic health benefits coverage, so

1 long as the actuarial equivalence requirement of
 2 paragraph (2)(A) is met.

3 “(b) APPLICATION OF MEDICARE ADVANTAGE WAIV-
 4 ER AUTHORITY.—The provisions of section 1857(i) shall
 5 apply with respect to Total Health plans in relation to em-
 6 ployment-based retiree health coverage in a manner simi-
 7 lar to the manner in which they applied to an MA plan
 8 in relation to employers, including authorizing the estab-
 9 lishment of separate premium amounts for enrollees in a
 10 Total Health plan by reason of such coverage and limita-
 11 tions on enrollment to Total Health eligible individuals en-
 12 rolled under such coverage.

13 “(c) DEFINITIONS.—For purposes of this section:

14 “(1) EMPLOYMENT-BASED RETIREE HEALTH
 15 COVERAGE.—The term ‘employment-based retiree
 16 health coverage’ means health insurance or other
 17 coverage of health care costs (whether provided by
 18 voluntary insurance coverage or pursuant to statu-
 19 tory or contractual obligation) for Total Health eligi-
 20 ble individuals (or for such individuals and their
 21 spouses and dependents) under a group health plan
 22 based on their status as retired participants in such
 23 plan.

24 “(2) SPONSOR.—The term ‘sponsor’ means a
 25 plan sponsor, as defined in section (16)(B) of the

1 Employee Retirement Income Security Act of 1974,
 2 in relation to a group health plan, except that, in the
 3 case of a plan maintained jointly by one employer
 4 and an employee organization and with respect to
 5 which the employer is the primary source of financ-
 6 ing, such term means such employer.

7 “(3) GROUP HEALTH PLAN.—The term ‘group
 8 health plan’ includes such a plan as defined in sec-
 9 tion 607(1) of the Employee Retirement Income Se-
 10 curity Act of 1974 and also includes the following:

11 “(A) FEDERAL AND STATE GOVERN-
 12 MENTAL PLANS.—Such a plan established or
 13 maintained for its employees by the Govern-
 14 ment of the United States, by the government
 15 of any State or political subdivision thereof, or
 16 by any agency or instrumentality of any of the
 17 foregoing, including a health benefits plan of-
 18 fered under chapter 89 of title 5, United States
 19 Code.

20 “(B) COLLECTIVELY BARGAINED PLANS.—
 21 Such a plan established or maintained under or
 22 pursuant to one or more collective bargaining
 23 agreements.

24 “(C) CHURCH PLANS.—Such a plan estab-
 25 lished and maintained for its employees (or

1 their beneficiaries) by a church or by a conven-
 2 tion or association of churches which is exempt
 3 from tax under section 501 of the Internal Rev-
 4 enue Code of 1986.

5 “COORDINATION WITH STATE MEDICAID PROGRAMS

6 “SEC. 1860C–11. (a) APPLICATION.—

7 “(1) IN GENERAL.—Subject to subsection
 8 (c)(2), a State may apply to the Secretary for the
 9 waiver of any or all requirements described in this
 10 subpart for plan years beginning on or after Janu-
 11 ary 1, 2017, with respect to a Total Health plan of-
 12 fered within the State for the purpose of coordi-
 13 nating that plan with its State plan under title XIX
 14 to ensure—

15 “(A) dually eligible individuals have full
 16 access to the services to which they are entitled;

17 “(B) the development of innovative care
 18 coordination and integration models; and

19 “(C) the elimination of financial misalign-
 20 ments that lead to poor quality and cost-shift-
 21 ing.

22 “(2) REQUIREMENTS.—Such application
 23 shall—

24 “(A) be filed at such time and in such
 25 manner as the Secretary may require;

1 “(B) contain such information as the Sec-
 2 retary may require, including—

3 “(i) a comprehensive description of
 4 the proposal and program to implement a
 5 plan meeting the requirements for a waiver
 6 under this section; and

7 “(ii) an analysis of the proposal dem-
 8 onstrating that the plan will not increase
 9 Federal Government expenditures; and

10 “(C) provide an assurance that, if ap-
 11 proved, the Total Health sponsor will offer the
 12 plan that is the subject of the proposal.

13 “(3) WAIVER CONSIDERATION AND TRANS-
 14 PARENCY.—

15 “(A) IN GENERAL.—An application for a
 16 waiver under this section shall be considered by
 17 the Secretary in accordance with the regula-
 18 tions described in subparagraph (B).

19 “(B) REGULATIONS.—Not later than 180
 20 days after the date of enactment of this sub-
 21 part, the Secretary shall promulgate regulations
 22 relating to waivers under this section that pro-
 23 vide—

1 “(i) a process for public notice and
 2 comment sufficient to ensure a meaningful
 3 level of public input;

4 “(ii) a process for the submission of
 5 an application for the waiver;

6 “(iii) a process for the submission to
 7 the Secretary of periodic reports by the
 8 State concerning the implementation of the
 9 program under the waiver; and

10 “(iv) a process for the periodic evalua-
 11 tion by the Secretary of the program under
 12 the waiver.

13 “(C) REPORT.—The Secretary shall annu-
 14 ally report to Congress concerning actions
 15 taken by the Secretary with respect to applica-
 16 tions for waivers under this section.

17 “(4) STATE OPTION TO BE A TOTAL HEALTH
 18 SPONSOR.—For purposes of this section, a State
 19 may elect to be the sponsor of a Total Health plan
 20 for residents of the State who are eligible for bene-
 21 fits under this title and title XIX or to apply on be-
 22 half of a Total Health sponsor offering a Total
 23 Health plan in the State.

24 “(5) COORDINATED WAIVER PROCESS.—The
 25 Secretary shall develop a process for coordinating

1 and consolidating the waiver processes applicable
 2 under the provisions of this section to ensure that
 3 individuals eligible to enroll in a plan offered under
 4 the waiver are initially able to do so during an an-
 5 nual, coordinated election period.

6 “(b) GRANTING OF WAIVERS.—

7 “(1) IN GENERAL.—The Secretary may grant a
 8 request for a waiver under subsection (a)(1) only if
 9 the Secretary determines that the proposed Total
 10 Health plan—

11 “(A) will provide coverage that is at least
 12 as comprehensive as the coverage described in
 13 section 1860C–2(a)(1) as certified by Office of
 14 the Actuary of the Centers for Medicare & Med-
 15 icaid Services;

16 “(B) will provide coverage and cost-sharing
 17 protections against excessive out-of-pocket
 18 spending that are at least as affordable as the
 19 provisions of this subtitle would provide; and

20 “(C) will not increase the Federal deficit.

21 “(c) SCOPE OF WAIVER.—

22 “(1) IN GENERAL.—Subject to paragraph (2),
 23 the Secretary shall determine the scope of a waiver
 24 granted with respect to a Total Health plan under
 25 subsection (a)(1).

1 “(2) LIMITATION.—The Secretary may only
2 waive provisions under this title and titles II, XI,
3 XIX, and XXI under a waiver under this section.

4 “(d) DETERMINATIONS BY THE SECRETARY.—

5 “(1) TIME FOR DETERMINATION.—The Sec-
6 retary shall make a determination under subsection
7 (a)(1) not later than 180 days after the receipt of
8 an application from a State under such subsection.

9 “(2) EFFECT OF DETERMINATION.—

10 “(A) GRANTING OF WAIVERS.—If the Sec-
11 retary determines to grant a waiver under sub-
12 section (a)(1), the Secretary shall notify the
13 Total Health sponsor involved of such deter-
14 mination and the terms and effectiveness of
15 such waiver.

16 “(B) DENIAL OF WAIVER.—If the Sec-
17 retary determines a waiver should not be grant-
18 ed under subsection (a)(1), the Secretary shall
19 notify the Total Health sponsor involved, in-
20 cluding the reasons therefor.

21 “(e) TERM OF WAIVER.—No waiver under this sec-
22 tion may extend over a period of longer than 5 years un-
23 less the Total Health sponsor requests continuation of
24 such waiver, and such request shall be deemed granted
25 unless the Secretary, within 90 days after the date of the

1 submission of the request to the Secretary, either denies
 2 such request in writing or informs the State in writing
 3 with respect to any additional information that is needed
 4 in order to make a final determination with respect to the
 5 request.

6 “DEFINITIONS AND MISCELLANEOUS PROVISIONS

7 “SEC. 1860C–12. (a) DEFINITIONS.—For purposes
 8 of this subpart:

9 “(1) BASIC HEALTH BENEFITS COVERAGE.—

10 The term ‘basic health benefits coverage’ means cov-
 11 erage of the health care items and services for which
 12 payment may be made under the original medicare
 13 fee-for-service program option.

14 “(2) INSURANCE RISK.—The term ‘insurance
 15 risk’ means, with respect to a participating health
 16 care provider, risk of the type commonly assumed
 17 only by insurers licensed by a State and does not in-
 18 clude payment variations designed to reflect per-
 19 formance-based measures of activities within the
 20 control of the health care provider.

21 “(3) MA PLAN; MEDICARE ADVANTAGE PLAN.—

22 The terms ‘MA plan’ and ‘Medicare Advantage plan’
 23 have the meaning given such terms in section
 24 1859(b)(1).

25 “(4) ORIGINAL MEDICARE FEE-FOR-SERVICE
 26 PROGRAM OPTION.—The term ‘original medicare fee-

for-service program option’ means the original medicare fee-for-service program under parts A and B, as modified by this subpart.

“(5) STANDARD HEALTH BENEFITS COVERAGE.—The term ‘standard health benefits coverage’ has the meaning given such term in section 1860C–2(b).

“(6) TOTAL HEALTH ELIGIBLE INDIVIDUAL.—The term ‘Total Health eligible individual’ has the meaning given such term in section 1860C–1(a)(3).

“(7) TOTAL HEALTH PLAN.—The term ‘Total Health plan’ means health benefits coverage that is offered—

“(A) under a policy, contract, or plan that has been approved under section 1860C–5(f); and

“(B) by a Total Health sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1860C–6(b).

“(8) TOTAL HEALTH SPONSOR.—The term ‘Total Health sponsor’ means a nongovernmental entity that is certified under this subpart as meeting the requirements and standards of this subpart for such a sponsor.

1 “(b) APPLICATION OF SUBPART 1 PROVISIONS AND
2 REGULATIONS UNDER THIS SUBPART.—For purposes of
3 applying provisions of subpart 1 under this subpart (and
4 regulations implementing such provisions) with respect to
5 a Total Health plan and a Total Health sponsor, unless
6 otherwise provided in this subpart, and to the extent con-
7 sistent with this subpart, such provisions (and regulations
8 implementing such provisions) shall be applied as the pro-
9 visions (and regulations) applied for plan years beginning
10 prior to January 1, 2017, and as if—

11 “(1) any reference to a Medicare Advantage
12 plan or an MA plan included a reference to a Total
13 Health plan;

14 “(2) any reference to an MA organization or a
15 provider-sponsored organization included a reference
16 to a Total Health sponsor;

17 “(3) any reference to a contract under section
18 1857 included a reference to a contract under sec-
19 tion 1860C–6(b);

20 “(4) any reference to subpart 1 included a ref-
21 erence to this subpart; and

22 “(5) any reference to an election period under
23 section 1851 were a reference to an enrollment pe-
24 riod under section 1860C–1.”.

1 **SEC. 2002. REPLACEMENT OF PART B PREMIUM WITH**
 2 **MEDICARE TOTAL HEALTH PROGRAM PLAN**
 3 **PREMIUM; OTHER TECHNICAL AND CON-**
 4 **FORMING AMENDMENTS.**

5 (a) REPLACEMENT OF PART B PREMIUM WITH
 6 MEDICARE TOTAL HEALTH PROGRAM PLAN PREMIUM.—
 7 Section 1839 of the Social Security Act (42 U.S.C. 1395r)
 8 is amended—

9 (1) in subsection (a)(2), by striking “The
 10 monthly premium” and inserting “Subject to sub-
 11 section (j),”; and

12 (2) by adding at the end the following new sub-
 13 section:

14 “(j) REPLACEMENT OF PART B PREMIUM WITH
 15 MEDICARE TOTAL HEALTH PROGRAM PLAN PREMIUM.—

16 “(1) IN GENERAL.—Notwithstanding the pre-
 17 ceding provisions of this section, except as provided
 18 in paragraph (2), on and after January 1, 2017, in
 19 lieu of the premium otherwise applicable under this
 20 section, the monthly premium of each Total Health
 21 eligible individual (as defined in section 1860C–
 22 1(a)(3)) shall be the monthly beneficiary premium
 23 determined under section 1860C–7 for the Total
 24 Health plan or the original medicare fee-for-service
 25 program option and the plan year involved.

1 “(2) INDIVIDUALS ENROLLED FOR COVERAGE
 2 UNDER PART B ONLY.—Individuals enrolled under
 3 this part only (and not entitled to, or enrolled for,
 4 benefits under part A) shall pay the premium that
 5 would have been calculated under this section but
 6 for the enactment of this subsection.

7 “(3) CREDITING OF PREMIUMS.—Premiums
 8 paid by each Total Health eligible individual enrolled
 9 in the original medicare fee-for-service program op-
 10 tion (as defined in section 1860E–13(a)(4)), shall be
 11 deposited in the Treasury to the credit of the Fed-
 12 eral Supplementary Medical Insurance Trust Fund
 13 under section 1841.”.

14 (b) OTHER TECHNICAL AND CONFORMING AMEND-
 15 MENTS.—Not later than 6 months after the date of the
 16 enactment of this Act, the Secretary of Health and
 17 Human Services shall submit to the appropriate commit-
 18 tees of Congress a legislative proposal providing for such
 19 technical and conforming amendments in the law as are
 20 required by the provisions of this part and part II.

1 **PART II—MEDICARE FEE-FOR-SERVICE REFORMS**

2 **SEC. 2011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-**

3 **POCKET EXPENDITURES FOR FEE-FOR-SERV-**

4 **ICE BENEFITS.**

5 Title XVIII of the Social Security Act (42 U.S.C.
6 1395 et seq.) is amended by adding at the end the fol-
7 lowing new section:

8 “PROTECTION AGAINST HIGH OUT-OF-POCKET
9 EXPENDITURES

10 “SEC. 1899B. (a) IN GENERAL.—Notwithstanding
11 any other provision of this title, in the case of an indi-
12 vidual entitled to, or enrolled for, benefits under part A
13 or enrolled in part B, if the amount of the out-of-pocket
14 cost-sharing of such individual for a year (beginning with
15 2015) equals or exceeds—

16 “(1) the first threshold annual out-of-pocket
17 limit under subsection (b)(1) but is less than the
18 second threshold annual out-of-pocket limit under
19 subsection (b)(2) for that year, section 1899D(a)
20 shall be applied by substituting ‘5 percent’ for ‘20
21 percent’; and

22 “(2) the second threshold annual out-of-pocket
23 limit under subsection (b)(2) for that year, there
24 shall not be any additional reduction under section
25 1899D for the remainder of the year (and the indi-

1 vidual shall not be responsible for additional out-of-
2 pocket cost-sharing incurred during that year).

3 “(b) AMOUNT OF ANNUAL OUT-OF-POCKET LIM-
4 ITS.—

5 “(1) FIRST THRESHOLD ANNUAL OUT-OF-POCK-
6 ET LIMIT.—The amount of the first threshold an-
7 nual out-of-pocket limit under this subsection shall
8 be—

9 “(A) for 2015, \$5,500; or

10 “(B) for a subsequent year, the amount
11 specified in this subsection for the preceding
12 year increased or decreased by the percentage
13 change in the Chained Consumer Price Index
14 for All Urban Consumers for the 12-month pe-
15 riod ending with June of such preceding year
16 (as published in its initial form by the Bureau
17 of Labor Statistics of the Department of Labor
18 as of the end of such period).

19 “(2) SECOND THRESHOLD ANNUAL OUT-OF-
20 POCKET LIMIT.—The amount of the second thresh-
21 old annual out-of-pocket limit under this subsection
22 shall be—

23 “(A) for 2015, \$7,500; or

24 “(B) for a subsequent year, the amount
25 specified in this subsection for the preceding

year increased or decreased by the percentage change in the Chained Consumer Price Index for All Urban Consumers for the 12-month period ending with June of such preceding year (as published in its initial form by the Bureau of Labor Statistics of the Department of Labor as of the end of such period).

“(3) ROUNDING.—If any amount determined under subparagraph (A) or (B) is not a multiple of \$5, such amount shall be rounded to the nearest multiple of \$5.

“(c) OUT-OF-POCKET COST-SHARING DEFINED.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), in this section, the term ‘out-of-pocket cost-sharing’ means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

“(A) deductibles, coinsurance and copayments applicable under part A or B; or

“(B) for items and services that would have otherwise been covered under part A or B but for the exhaustion of those benefits.

“(2) CERTAIN COSTS NOT INCLUDED.—

“(A) NON-COVERED ITEMS AND SERVICES.—Expenses incurred for items and serv-

1 ices which are not included (or treated as being
2 included) under part A or B shall not be con-
3 sidered incurred expenses for purposes of deter-
4 mining out-of-pocket cost-sharing under para-
5 graph (1).

6 “(B) ITEMS AND SERVICES NOT FUR-
7 NISHED ON AN ASSIGNMENT-RELATED BASIS.—
8 If an item or service is furnished to an indi-
9 vidual under this title and is not furnished on
10 an assignment-related basis, any additional ex-
11 penses the individual incurs above the amount
12 the individual would have incurred if the item
13 or service was furnished on an assignment-re-
14 lated basis shall not be considered incurred ex-
15 penses for purposes of determining out-of-pock-
16 et cost-sharing under paragraph (1).

17 “(3) SOURCE OF PAYMENT.—For purposes of
18 paragraph (1), the Secretary shall consider expenses
19 to be incurred by the individual without regard to
20 whether the individual or another person, including
21 a State program or other third-party coverage, has
22 paid for such expenses.

23 “(d) ANNOUNCEMENT OF ANNUAL OUT-OF-POCKET
24 LIMIT AND UNIFIED DEDUCTIBLE.—The Secretary shall
25 (beginning in 2014) announce (in a manner intended to

1 provide notice to all interested parties) the annual out-
 2 of-pocket limit under this section and the unified deduct-
 3 ible under section 1899C that will be applicable for the
 4 succeeding year.”.

5 **SEC. 2012. UNIFIED MEDICARE DEDUCTIBLE.**

6 (a) IN GENERAL.—Title XVIII of the Social Security
 7 Act (42 U.S.C. 1395 et seq.), as amended by section 2011,
 8 is amended by adding at the end the following new section:

9 “UNIFIED PART A AND B DEDUCTIBLE

10 “SEC. 1899C. (a) IN GENERAL.—Notwithstanding
 11 any other provision of this title, subject to subsection (d),
 12 for a year (beginning with 2015), in the case of an indi-
 13 vidual entitled to, or enrolled for, benefits under part A
 14 or enrolled in part B—

15 “(1) the amount otherwise payable under part
 16 A and the total amount of expenses incurred by the
 17 individual during a year which would (except for this
 18 section) constitute incurred expenses for which bene-
 19 fits payable under section 1833(a) are determinable,
 20 shall be reduced by the amount of the unified de-
 21 ductible under subsection (b); and

22 “(2) the individual shall be responsible for pay-
 23 ment of such amount.

24 “(b) AMOUNT OF UNIFIED DEDUCTIBLE.—

25 “(1) IN GENERAL.—The amount of the unified
 26 deductible under this section shall be—

1 “(A) for 2015, \$550; or

2 “(B) for a subsequent year, the amount
3 specified in this subsection for the preceding
4 year increased or decreased by the percentage
5 change in the Chained Consumer Price Index
6 for All Urban Consumers for the 12-month pe-
7 riod ending with June of such preceding year
8 (as published in its initial form by the Bureau
9 of Labor Statistics of the Department of Labor
10 as of the end of such period).

11 “(2) ROUNDING.—If any amount determined
12 under paragraph (1) is not a multiple of \$5, such
13 amount shall be rounded to the nearest multiple of
14 \$5.

15 “(c) APPLICATION TO ALL ITEMS AND SERVICES.—
16 The unified deductible under this section for a year shall
17 be applied as follows:

18 “(1) With respect to items and services covered
19 under part A, such unified deductible shall be ap-
20 plied on the basis of the amount that is payable for
21 such items and services without regard to any copay-
22 ments or coinsurance and before the application of
23 any such copayments or coinsurance.

24 “(2) With respect to items and services covered
25 under part B, such unified deductible shall be ap-

1 plied on the basis of the total amount of the ex-
2 penses incurred by the individual during a year
3 which would, except for the application of the unified
4 deductible, constitute incurred expenses for which
5 items and services are payable under part B, without
6 regard to any copayments or coinsurance and before
7 the application of any such copayments or coinsur-
8 ance.

9 “(3)(A) Except as provided in subparagraph
10 (B), such unified deductible shall be applied with re-
11 spect to all items and services covered under parts
12 A and B and in lieu of the deductibles described in
13 sections 1813(b) and 1833(b) or otherwise.

14 “(B) The deductible applicable to blood under
15 sections 1813 and 1833 shall apply to blood instead
16 of such unified deductible.

17 “(d) TREATMENT OF INDIVIDUALS NOT ENROLLED
18 IN BOTH PARTS A AND B.—The Secretary shall establish
19 procedures under which an individual who entitled to, or
20 enrolled for, benefits under part A or enrolled in part B
21 (but not both) will continue to be subject to a deductible
22 under this title that is comparable to the deductible the
23 individual would have been subject to if this section had
24 not been enacted.”.

1 (b) CLARIFICATION REGARDING APPLICATION
 2 UNDER MEDICARE ADVANTAGE.—Section
 3 1852(a)(1)(B)(iii) of the Social Security Act (42 U.S.C.
 4 1395w–22(a)(1)(B)(iii)) is amended by adding at the end
 5 the following new sentence: “For plan years 2015 and
 6 2016, the preceding sentence shall be applied to take into
 7 account the application of sections 1899B, 1899C, and
 8 1899D.”.

9 **SEC. 2013. UNIFORM MEDICARE COINSURANCE RATE.**

10 (a) IN GENERAL.—Title XVIII of the Social Security
 11 Act (42 U.S.C. 1395 et seq.), as amended by sections
 12 2011 and 2012, is amended by adding at the end the fol-
 13 lowing new section:

14 “UNIFORM PART A AND B COINSURANCE RATE

15 “SEC. 1899D. (a) IN GENERAL.—Notwithstanding
 16 any other provision of this title, in the case of an indi-
 17 vidual entitled to, or enrolled for, benefits under part A
 18 or enrolled in part B, after the application of the unified
 19 deductible under section 1899C and subject to the limit
 20 on annual out-of-pocket expenses under section 1899B,
 21 the amount otherwise payable under part A and the total
 22 amount of expenses incurred by the individual during a
 23 year (beginning in 2015) which would (except for this sec-
 24 tion) constitute incurred expenses for which benefits are
 25 payable under part B, shall be reduced by a coinsurance
 26 of 20 percent of such amount.

1 “(b) APPLICATION TO ALL ITEMS AND SERVICES.—

2 The uniform coinsurance under this section for a year
3 shall be applied as follows:

4 “(1) With respect to items and services covered
5 under part A, such uniform coinsurance shall be ap-
6 plied on the basis of the amount that is payable for
7 such items and services.

8 “(2) With respect to items and services covered
9 under part B, such uniform coinsurance shall be ap-
10 plied on the basis of the total amount of the ex-
11 penses incurred by the individual during a year
12 which would, except for the application of the unified
13 deductible, constitute incurred expenses from which
14 items and services are payable under part B.

15 “(3)(A) Except as provided in subparagraph
16 (B), such uniform coinsurance shall be applied with
17 respect to all items and services covered under parts
18 A and B and in lieu of any other copayments or co-
19 insurance under such parts.

20 “(B) Coinsurance for blood under this title
21 shall be determined under the rules that were appli-
22 cable to blood on December 31, 2014, rather than
23 under this section.”.

24 (b) CONFORMING AMENDMENTS.—

1 (1) Section 1813 of the Social Security Act (42
2 U.S.C. 1395e) is amended—

3 (A) in subsection (a), by inserting “Subject
4 to sections 1899B, 1899C, and 1899D:” before
5 paragraph (1); and

6 (B) in subsection (b), by inserting “Sub-
7 ject to sections 1899B, 1899C, and 1899D:”
8 before paragraph (1).

9 (2) Section 1833 of the Social Security Act (42
10 U.S.C. 1395l) is amended—

11 (A) in subsection (a), in the matter pre-
12 ceding paragraph (1), by inserting “and sec-
13 tions 1899B, 1899C, and 1899D” after “suc-
14 ceeding provisions of this section”;

15 (B) in subsection (b), in the first sentence,
16 by striking “Before applying” and inserting
17 “Subject to sections 1899B, 1899C, and
18 1899D, before applying”;

19 (C) in subsection (c)(1), in the matter pre-
20 ceding subparagraph (A), by inserting “subject
21 to sections 1899B, 1899C, and 1899D,” after
22 “this part,”;

23 (D) in subsection (f), by striking “In es-
24 tablishing” and inserting “Subject to sections

1 1899B, 1899C, and 1899D, in establishing”;
 2 and

3 (E) in subsection (g)(1), by inserting “and
 4 sections 1899B, 1899C, and 1899D” and
 5 “paragraphs (4) and (5)”.

6 (3) Section 1905(p)(3) of the Social Security
 7 Act (42 U.S.C. 1396d(p)(3)) is amended—

8 (A) in subparagraph (B), striking “section
 9 1813” and inserting “sections 1813 and
 10 1899C”; and

11 (B) in subparagraph (C), by striking “and
 12 section 1833(b)” and inserting “, 1833(b), and
 13 1899C”.

14 **SEC. 2014. PROHIBITION ON FIRST-DOLLAR COVERAGE**
 15 **UNDER MEDIGAP POLICIES AND DEVELOP-**
 16 **MENT OF NEW STANDARDS FOR MEDIGAP**
 17 **POLICIES.**

18 Section 1882 of the Social Security Act (42 U.S.C.
 19 1395ss) is amended by adding at the end the following
 20 new subsections:

21 “(z) PROHIBITION ON FIRST-DOLLAR COVERAGE
 22 AND DEVELOPMENT OF NEW STANDARDS FOR MEDICARE
 23 SUPPLEMENTAL POLICIES.—

24 “(1) DEVELOPMENT.—The Secretary shall re-
 25 quest the National Association of Insurance Com-

1 missioners to review and revise the standards for
2 benefit packages under subsection (p)(1), taking into
3 account the changes in benefits resulting from the
4 enactment of the The Dollar for Dollar Act of 2012
5 and to otherwise update standards to include the re-
6 quirements for cost-sharing described in paragraph
7 (2). Such revisions shall be made consistent with the
8 rules applicable under subsection (p)(1)(E) with the
9 reference to the ‘1991 NAIC Model Regulation’
10 deemed a reference to the NAIC Model Regulation
11 as published in the Federal Register on December 4,
12 1998, and as subsequently updated by the National
13 Association of Insurance Commissioners to reflect
14 previous changes in law and the reference to ‘date
15 of enactment of this subsection’ deemed a reference
16 to the date of enactment of the The Dollar for Dol-
17 lar Act of 2012. To the extent practicable, such revi-
18 sion shall provide for the implementation of revised
19 standards for benefit packages as of January 1,
20 2015.

21 “(2) COST-SHARING REQUIREMENTS.—The
22 cost-sharing requirements described in this para-
23 graph are that, notwithstanding any other provision
24 of law, no medicare supplemental policy may provide
25 for coverage of—

1 “(A) any portion of the unified deductible
2 under section 1899C(b) for the year; and

3 “(B) more than 50 percent of the cost-
4 sharing (excluding premiums) otherwise appli-
5 cable under parts A and B after the individual
6 has met the unified deductible under section
7 1899C(b) for the year and before the individual
8 has reached the first threshold annual out-of-
9 pocket limit under section 1899B(b)(1) for the
10 year.

11 “(3) RENEWABILITY.—The renewability re-
12 quirement under subsection (q)(1) shall be satisfied
13 with the renewal of the revised package under para-
14 graph (1) that most closely matches the policy in
15 which the individual was enrolled prior to such revi-
16 sion.

17 “(aa) LIMITATION ON ISSUING NEW MEDICARE SUP-
18 PLEMENTAL POLICIES AFTER 2016.—

19 “(1) IN GENERAL.—Notwithstanding any other
20 provision of law, a medicare supplemental policies
21 may not be issued to an individual after December
22 31, 2016, unless the individual was covered under a
23 medicare supplemental policy as of such date.

1 “(2) RENEWALS AND NEW POLICIES.—Nothing
 2 in this subsection shall be construed as prohib-
 3 iting—

4 “(A) the renewal after December 31, 2016,
 5 of a medicare supplemental policy that was
 6 issued on or before such date; or

7 “(B) the issuance of a new medicare sup-
 8 plemental policy after such date as long as the
 9 individual was covered under any medicare sup-
 10 plemental policy as of such date.”.

11 **PART III—ANNUAL REPORT TO CONGRESS**

12 **SEC. 2021. ANNUAL REPORT TO CONGRESS.**

13 (a) IN GENERAL.—Not later than July 1, 2016, and
 14 annually thereafter, the Secretary of Health and Human
 15 Services shall submit to the Committee on Finance and
 16 the Special Committee on Aging of the Senate and to the
 17 Committee on Ways and Means and the Committee on En-
 18 ergy and Commerce of the House of Representatives a re-
 19 port on the provisions of, and amendments made by, parts
 20 I and II.

21 (b) CONTENTS.—The report submitted under sub-
 22 section (a) shall contain the following information:

23 (1) An evaluation of the financial impact of
 24 such provisions and amendments.

1 (2) An evaluation of changes in access to physi-
 2 cians and other health care providers as a result of
 3 such provisions and amendments.

4 (3) An evaluation of changes in beneficiary sat-
 5 isfaction under the Medicare program as a result of
 6 such provisions and amendments.

7 (4) Such other information as the Secretary de-
 8 termines to be appropriate.

9 **Subtitle B—Elimination of Exemp-**
 10 **tion of Medicare Payments to**
 11 **Physicians Under Statutory**
 12 **PAYGO**

13 **SEC. 2101. ELIMINATION OF EXEMPTION OF MEDICARE**
 14 **PAYMENTS TO PHYSICIANS UNDER STATU-**
 15 **TORY PAYGO.**

16 (a) IN GENERAL.—Section 7 of the Statutory Pay-
 17 As-You-Go Act of 2010 (2 U.S.C. 936) is amended—

18 (1) in subsection (a), by striking paragraph (1);

19 and

20 (2) by striking subsection (c).

21 (b) EFFECTIVE DATE.—The amendments made by
 22 subsection (a) shall take effect on the date of the enact-
 23 ment of this Act.

1 **Subtitle C—Adjustments to Medi-**
 2 **care Part B and D Premiums for**
 3 **High-Income Beneficiaries**

4 **SEC. 2201. ADJUSTMENTS TO MEDICARE PART B AND D**
 5 **PREMIUMS FOR HIGH-INCOME BENE-**
 6 **FICIARIES.**

7 (a) IN GENERAL.—Section 1839(i) of the Social Se-
 8 curity Act (42 U.S.C. 1395r(i)) is amended—

9 (1) in paragraph (2)(A), by inserting (or, in the
 10 case of 2013 or a subsequent year, \$50,000) after
 11 “\$80,000”; and

12 (2) in paragraph (3)—

13 (A) in subparagraph (A)(i)—

14 (i) by inserting “applicable” before
 15 “table”; and

16 (ii) by inserting “and year” after “in-
 17 dividual”; and

18 (B) in subparagraph (C)(i)—

19 (i) by striking “(i) IN GENERAL.—”
 20 and inserting “(i)(I) FOR 2007 THROUGH
 21 2012.—For each of 2007 through 2012:”;
 22 and

23 (ii) by adding at the end the following
 24 new subclause:

1 “(II) FOR 2013 AND SUBSEQUENT
2 YEARS.—For 2013 or a subsequent year:

“If the modified adjusted gross income is:	The applicable percentage is:
More than \$50,000 but not more than \$85,000	35 percent
More than \$85,000 but not more than \$107,000	40 percent
More than \$107,000 but not more than \$160,000	55 percent
More than \$160,000 but not more than \$214,000	70 percent
More than \$214,000 but not more than \$250,000	85 percent
More than \$250,000	100 percent.”.

3 (b) EXTENSION OF TEMPORARY ADJUSTMENT TO IN-
4 COME THRESHOLDS.—

5 (1) IN GENERAL.—Section 1839(i)(6) of the
6 Social Security Act (42 U.S.C. 1395r(i)(6)) is
7 amended—

8 (A) in the matter preceding subparagraph
9 (A), by striking “December 31, 2019” and in-
10 serting “December 31, 2021”;

11 (B) in subparagraph (A), by striking
12 “equal to such amount for 2010; and” and in-
13 serting the following: “equal to—

14 “(i) in the case of each of 2011 and
15 2012, such amount for 2010; and

16 “(ii) in the case of each of 2013
17 through 2021, such amount for 2013;
18 and”; and

1 (C) in subparagraph (B), by striking
 2 “equal to such dollar amounts for 2010.” and
 3 inserting the following: “equal to—
 4 “(i) in the case of each of 2011 and
 5 2012, such dollar amounts for 2010; and
 6 “(ii) in the case of each of 2013
 7 through 2021, such dollar amounts for
 8 2013.”.

9 (2) CONFORMING AMENDMENT.—Section
 10 1839(i)(5)(A) of the Social Security Act (42 U.S.C.
 11 1395r(i)(5)(A)) is amended by inserting “for such
 12 year” after “paragraph (2) or (3)”.

13 **Subtitle D—Increase in the** 14 **Medicare Eligibility Age**

15 **SEC. 2301. INCREASE IN THE MEDICARE ELIGIBILITY AGE.**

16 Section 226 of the Social Security Act (42 U.S.C.
 17 426) is amended by adding at the end the following new
 18 subsection:

19 “(k) INCREASING MEDICARE QUALIFYING AGE.—

20 “(1) IN GENERAL.—Notwithstanding any other
 21 provision of law, any reference in this section, title
 22 XVIII, or title XIX (insofar as it relates to the eligi-
 23 bility age for Medicare benefits under title XVIII) to
 24 ‘age 65’ shall be deemed a reference to the Medicare
 25 qualifying age specified in paragraph (2).

1 “(2) MEDICARE QUALIFYING AGE SPECIFIED.—

2 The Medicare qualifying age specified in this para-
3 graph is determined as follows:

4 “(A) In the case of an individual who at-
5 tains 65 years of age before January 1, 2014,
6 the Medicare qualifying age is 65 years of age.

7 “(B) In the case of an individual who at-
8 tains 65 years of age in a year after 2013, and
9 before 2025, the Medicare qualifying age is the
10 Medicare qualifying age specified in this para-
11 graph for the previous year increased by 2
12 months.

13 “(C) In the case of an individual who at-
14 tains 65 years of age in a year after 2024, the
15 Medicare qualifying age is 67 years of age.”.

16 **Subtitle E—Other Provisions**

17 **SEC. 2401. LIMITATION ON MEDICARE PAYMENTS FOR DI-**

18 **RECT GRADUATE MEDICAL EDUCATION**

19 **(DGME).**

20 Section 1886(h)(2)(D) of the Social Security Act (42
21 U.S.C. 1395ww(h)(2)(D)) is amended by adding at the
22 end the following new clause:

23 “(v) CAP ON APPROVED FTE RESI-
24 DENT AMOUNT.—

1 “(I) IN GENERAL.—The ap-
2 proved FTE resident amount for a
3 hospital for a cost reporting period be-
4 ginning during fiscal year 2013 or a
5 subsequent fiscal year shall not be
6 more than the applicable amount for
7 the year.

8 “(II) APPLICABLE AMOUNT.—
9 For purposes of subclause (I), the ap-
10 plicable amount for a year shall be an
11 amount equal to 120 percent of the
12 national average salary paid to resi-
13 dents in 2010, updated through the
14 year involved by the Chained Con-
15 sumer Price Index.

16 “(III) CHAINED CONSUMER
17 PRICE INDEX.—In subclause (II), the
18 term ‘Chained Consumer Price Index’
19 means the initial Chained Consumer
20 Price Index for all-urban consumers
21 published by the Department of
22 Labor.”.

1 **SEC. 2402. REDUCTION IN MEDICARE INDIRECT GRADUATE**
 2 **MEDICAL EDUCATION (IME) PAYMENTS.**

3 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) of the
 4 Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is
 5 amended—

6 (1) in subclause (XI), by striking “and” at the
 7 end;

8 (2) in subclause (XII)—

9 (A) by inserting “and before October 1,
 10 2012,” after “2007,”; and

11 (B) by striking the period at the end and
 12 inserting “; and”; and

13 (3) by adding at the end the following new sub-
 14 clause:

15 “(XIII) on or after October 1, 2012, ‘c’ is
 16 equal to 0.54.”.

17 (b) CONFORMING AMENDMENT RELATING TO DE-
 18 TERMINATION OF STANDARDIZED AMOUNT.—Section
 19 1886(d)(2)(C)(i) of the Social Security Act (42 U.S.C.
 20 1395ww(d)(2)(C)(i)) is amended by inserting “or of sec-
 21 tion 2402(a) of the The Dollar for Dollar Act of 2012”
 22 after “Act of 1997”.

1 **SEC. 2403. ACCELERATION OF APPLICATION OF PRODUC-**
 2 **TIVITY ADJUSTMENT TO MEDICARE HOME**
 3 **HEALTH PROSPECTIVE PAYMENT AMOUNTS.**

4 Section 1895(b)(3)(B)(vi)(I) of the Social Security
 5 Act (42 U.S.C. 1395fff(b)(3)(B)(vi)(I)) is amended by
 6 striking “2015” and inserting “2013”.

7 **SEC. 2404. ACCELERATION OF REBASING OF MEDICARE**
 8 **HOME HEALTH PROSPECTIVE PAYMENT**
 9 **AMOUNTS.**

10 Section 1895(b)(3)(A)(iii)(II) of the Social Security
 11 Act (42 U.S.C. 1395fff(b)(3)(A)(iii)(II)) is amended—

12 (1) in the first sentence—

13 (A) by striking “4-year” and inserting “2-
 14 year”; and

15 (B) by striking “2017” and inserting
 16 “2015”; and

17 (2) by striking the second sentence.

18 **SEC. 2405. REDUCTION OF BAD DEBT TREATED AS AN AL-**
 19 **LOWABLE COST.**

20 (a) HOSPITALS.—Section 1861(v)(1)(T) of the Social
 21 Security Act (42 U.S.C. 1395x(v)(1)(T)) is amended—

22 (1) in clause (iv), by striking “and” at the end;

23 (2) in clause (v)—

24 (A) by striking “or a subsequent fiscal
 25 year”; and

1 (B) by striking the period at the end and
 2 inserting a comma; and

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

4 “(vi) for cost reporting periods beginning dur-
 5 ing fiscal year 2014, by 48 percent of such amount
 6 otherwise allowable,

7 “(vii) for cost reporting periods beginning dur-
 8 ing fiscal year 2015, by 61 percent of such amount
 9 otherwise allowable,

10 “(viii) for cost reporting periods beginning dur-
 11 ing fiscal year 2016, by 74 percent of such amount
 12 otherwise allowable,

13 “(ix) for cost reporting periods beginning dur-
 14 ing fiscal year 2017, by 87 percent of such amount
 15 otherwise allowable, and

16 “(x) for cost reporting periods beginning during
 17 fiscal year 2018 or a subsequent fiscal year, by 100
 18 percent of such amount otherwise allowable.”.

19 (b) SKILLED NURSING FACILITIES.—Section
 20 1861(v)(1)(V) of the Social Security Act (42 U.S.C.
 21 1395x(v)(1)(V)) is amended—

22 (1) by moving subclauses (I) and (II) of clause
 23 (i) and subclauses (I) through (IV) of clause (ii) two
 24 ems to the right; and

25 (2) in clause (i)—

1 (A) in subclause (I), by striking “and” at
2 the end;

3 (B) in subclause (II)—

4 (i) by striking “or a subsequent fiscal
5 year”; and

6 (ii) by striking the period at the end
7 and inserting a semicolon; and

8 (C) by adding at the end the following:

9 “(III) for cost reporting periods beginning
10 during fiscal year 2014, by 48 percent of such
11 amount otherwise allowable;

12 “(IV) for cost reporting periods beginning
13 during fiscal year 2015, by 61 percent of such
14 amount otherwise allowable;

15 “(V) for cost reporting periods beginning
16 during fiscal year 2016, by 74 percent of such
17 amount otherwise allowable;

18 “(VI) for cost reporting periods beginning
19 during fiscal year 2017, by 87 percent of such
20 amount otherwise allowable; and

21 “(VII) for cost reporting periods beginning
22 during fiscal year 2018 or a subsequent fiscal
23 year, by 100 percent of such amount otherwise
24 allowable.”.

1 (c) CERTAIN OTHER PROVIDERS.—Section
2 1861(v)(1)(W)(i) of the Social Security Act (42 U.S.C.
3 1395x(v)(1)(W)(i)) is amended—

4 (1) in subclause (II), by striking “and” at the
5 end;

6 (2) in subclause (III)—

7 (A) by striking “a subsequent fiscal year”
8 and inserting “fiscal year 2015”; and

9 (B) by striking the period at the end and
10 inserting a semicolon; and

11 (3) by adding at the end the following:

12 “(IV) for cost reporting periods beginning dur-
13 ing fiscal year 2016, by 48 percent of such amount
14 otherwise allowable;

15 “(V) for cost reporting periods beginning dur-
16 ing fiscal year 2017, by 61 percent of such amount
17 otherwise allowable;

18 “(VI) for cost reporting periods beginning dur-
19 ing fiscal year 2018, by 74 percent of such amount
20 otherwise allowable;

21 “(VII) for cost reporting periods beginning dur-
22 ing fiscal year 2019, by 87 percent of such amount
23 otherwise allowable; and

24 “(VIII) for cost reporting periods beginning
25 during fiscal year 2020 or a subsequent fiscal year,

1 by 100 percent of such amount otherwise allow-
 2 able.”.

3 **TITLE III—SOCIAL SECURITY**

4 **SEC. 3101. ADJUSTMENTS TO BEND POINTS IN DETER-** 5 **MINING PRIMARY INSURANCE AMOUNT.**

6 Section 215(a)(1) of the Social Security Act (42
 7 U.S.C. 415(a)(1)) is amended—

8 (1) in subparagraph (A), in the matter pre-
 9 ceding clause (i), by inserting “who initially becomes
 10 eligible for old-age or disability insurance benefits,
 11 or who dies (before becoming eligible for such bene-
 12 fits), in any calendar year after 1979 and before
 13 2017” after “individual”;

14 (2) in subparagraph (B)(ii), in the matter pre-
 15 ceding subclause (I), by inserting “and before 2017”
 16 after “after 1979”;

17 (3) in subparagraph (C)(i), by inserting “or
 18 (E)” after “(A)”;

19 (4) by adding at the end the following:

20 “(E)(i) The primary insurance amount of an indi-
 21 vidual who initially becomes eligible for old-age or dis-
 22 ability insurance benefits, or who dies (before becoming
 23 eligible for such benefits), in any calendar year after 2016
 24 shall (except as otherwise provided in this section) be
 25 equal to the sum of—

1 “(I) 90 percent of the individual’s average in-
2 dexed monthly earnings (determined under sub-
3 section (b)) to the extent that such earnings do not
4 exceed the amount established for purposes of this
5 subclause by clause (ii),

6 “(II) 30 percent of the individual’s average in-
7 dexed monthly earnings to the extent that such
8 earnings exceed the amount established for purposes
9 of subclause (I) but do not exceed the amount estab-
10 lished for purposes of this subclause by clause (ii),

11 “(III) 10 percent of the individual’s average in-
12 dexed monthly earnings to the extent that such
13 earnings exceed the amount established for purposes
14 of subclause (II) but do not exceed the amount es-
15 tablished for purposes of this subclause by clause
16 (ii), and

17 “(IV) 5 percent of the individual’s average in-
18 dexed monthly earnings to the extent that such
19 earnings exceed the amount established for purposes
20 of subclause (III),

21 rounded, if not a multiple of \$0.10, to the next lower mul-
22 tiple of \$0.10, and thereafter increased as provided in sub-
23 section (i).

24 “(ii) For individuals who initially become eligible for
25 old-age or disability insurance benefits, or who die (before

1 becoming eligible for such benefits) in the calendar year
 2 2017 or later, the amount established for purposes of sub-
 3 clauses (I), (II), and (III) of subparagraph (E)(i) shall
 4 be \$180, \$736, and \$1,085, respectively, as if such
 5 amount was applicable with respect to 1979 and was ad-
 6 justed for years after 1979 in the same manner as pro-
 7 vided under subparagraph (B)(ii), without regard to the
 8 limitation that such adjustment only applies to individuals
 9 who initially become eligible for old-age benefits or dis-
 10 ability insurance benefits, or who die (before becoming eli-
 11 gible for benefits) before 2017.

12 “(iii)(I) Notwithstanding clauses (i) and (ii), in the
 13 case of any individual who becomes eligible for old-age or
 14 disability insurance benefits, or who dies (before becoming
 15 eligible for such benefits) in any calendar year after 2016
 16 and before 2051, the primary insurance amount of the in-
 17 dividual shall be equal to the sum of—

18 “(aa) the primary insurance amount determined
 19 for the individual under subparagraphs (A) and (B)
 20 (without regard to the limitation that such subpara-
 21 graphs apply only to individuals who initially become
 22 eligible for old-age benefits or disability insurance
 23 benefits, or who die (before becoming eligible for
 24 benefits) before 2017) multiplied by the applicable

1 phase-in factor for the calendar year under sub-
 2 clause (II); and

3 “(bb) the primary insurance amount deter-
 4 mined for the individual under this subparagraph
 5 (other than under this clause) multiplied by the ap-
 6 plicable phase-in factor for the calendar year under
 7 subclause (II).

8 “(II) For purposes of—

9 “(aa) subclause (I)(aa), the applicable phase-in
 10 factor for calendar year 2017, is the quotient of 33
 11 divided by 34, and for each year thereafter is the
 12 quotient of—

13 “(AA) the numerator applicable for the
 14 preceding year reduced by 1, divided by

15 “(BB) 34; and

16 “(bb) subclause (I)(bb), the applicable phase-in
 17 factor for calendar year 2017 is the quotient of 1 di-
 18 vided by 34, and for each year thereafter is the
 19 quotient of—

20 “(AA) the numerator applicable for the
 21 preceding year increased by 1, divided by

22 “(BB) 34.”.

1 **SEC. 3102. ADJUSTMENT TO CALCULATION OF BENEFIT**
 2 **COMPUTATION YEARS.**

3 (a) IN GENERAL.—Clause (i) of section 215(b)(2)(A)
 4 of the Social Security Act (42 U.S.C. 415(b)(2)(A)) is
 5 amended to read as follows:

6 “(i) in the case of an individual who is entitled
 7 to old-age insurance benefits (except as provided in
 8 the second sentence of this subparagraph), or who
 9 has died—

10 “(I) before January 1, 2014, by 5 years;

11 “(II) after December 31, 2013, and before
 12 January 1, 2015, by 4 years;

13 “(III) after December 31, 2014, and be-
 14 fore January 1, 2016, by 3 years; and

15 “(IV) after December 31, 2015, and before
 16 January 1, 2017, by 2 years; and”.

17 (b) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to benefits payable for months be-
 19 ginning after December 31, 2013.

20 **SEC. 3103. MINIMUM SOCIAL SECURITY BENEFIT.**

21 (a) IN GENERAL.—Section 215 of the Social Security
 22 Act (42 U.S.C. 415) is amended by adding at the end the
 23 following:

24 “Minimum Monthly Insurance Benefit

25 “(j)(1) Notwithstanding the preceding provisions of
 26 this section—

1 “(A) subject to paragraph (3), the primary in-
 2 surance amount of any individual who is credited
 3 with at least 10 years of coverage and who initially
 4 becomes eligible for old-age or disability insurance
 5 benefits or dies (before becoming eligible for such
 6 benefits) for a month beginning after December 31,
 7 2016 (in this subsection referred to as a ‘qualified
 8 individual’), shall be equal to the greater of—

9 “(i) the primary insurance amount deter-
 10 mined under this section (without regard to this
 11 subsection), or

12 “(ii) the minimum monthly insurance ben-
 13 efit determined under paragraph (2), and

14 “(B) any recomputation of the primary insur-
 15 ance amount of a qualified individual shall not result
 16 in a primary insurance amount less than the pri-
 17 mary insurance amount as in effect immediately
 18 prior to such recomputation.

19 “(2) For purposes of this subsection, the term ‘min-
 20 imum monthly insurance benefit’ means $\frac{1}{12}$ of the appli-
 21 cable percentage of the adjusted minimum benefit level (as
 22 defined in paragraph (5)).

23 “(3)(A) For purposes of this subsection, subject to
 24 subparagraph (B), the applicable percentage shall be 125
 25 percent reduced by the number of percentage points deter-

1 mined under subparagraph (B)(ii) for each year of cov-
 2 erage of the qualified individual less than 30.

3 “(B)(i) In the case of an individual who initially be-
 4 comes eligible for disability insurance benefits under sec-
 5 tion 223 before attaining age 62, or who dies before at-
 6 taining age 62, in a month beginning after December 31,
 7 2016, and who is credited with at least 5 years of cov-
 8 erage, the individual shall be treated as a qualified indi-
 9 vidual and the applicable percentage shall be 125 reduced
 10 by the number of percentage points determined under
 11 clause (ii) for each year of coverage of the qualified indi-
 12 vidual less than the number as determined under clause
 13 (iii).

14 “(ii) The number of percentage points under this
 15 clause shall be determined by—

16 “(I) dividing the number of the qualifying indi-
 17 vidual’s elapsed years (as defined in subsection
 18 (b)(2)(B)(iii)) by 40;

19 “(II) multiplying the result under subclause (I)
 20 by 20; and

21 “(III) dividing 125 by the result under sub-
 22 clause (II) and rounding to the nearest one hun-
 23 dredth of 1 percentage point.

24 “(iii) The number of years of coverage under this
 25 clause shall be determined by multiplying the ratio deter-

1 mined under clause (ii)(I) by 30 and rounding to the next
 2 lower whole number.

3 “(4) For purposes of this subsection, a year of cov-
 4 erage is a calendar year for which an individual is credited
 5 with 4 quarters of coverage.

6 “(5) For purposes of this subsection—

7 “(A) for individuals who initially become eligible
 8 for old-age or disability insurance benefits or die
 9 (before becoming eligible for such benefits) in 2017,
 10 the term ‘adjusted minimum benefit level’ means the
 11 weighted average of the Federal poverty threshold
 12 applicable to a family of 1 for 2009 (as determined
 13 by the Bureau of the Census), increased for each
 14 year occurring after 2009 and before 2018, by the
 15 percentage increase (rounded to the nearest one-
 16 tenth of 1 percent) in the Chained Consumer Price
 17 Index for All Urban Consumers (as published by the
 18 Bureau of Labor Statistics of the Department of
 19 Labor) for each such year; and

20 “(B) for individuals who initially become eligi-
 21 ble for old-age or disability insurance benefits or die
 22 (before becoming eligible for such benefits) in a year
 23 after 2017, the term ‘adjusted minimum benefit
 24 level’ means the amount specified in subparagraph
 25 (A), multiplied by the quotient described in sub-

1 section (b)(3)(A)(ii), except that the reference to
 2 ‘the computation base year for which the determina-
 3 tion is made’ in such subsection shall be deemed in-
 4 stead to be a reference to ‘2009’.

5 “(6) The provisions of this subsection shall not apply
 6 in the case of an individual whose primary insurance
 7 amount would otherwise be computed under subsection
 8 (a)(7).”.

9 (b) CONFORMING AMENDMENT.—Section 202(a) of
 10 such Act (42 U.S.C. 402(a)) is amended in the last sen-
 11 tence by striking “section 215(a)” and inserting “section
 12 215”.

13 **SEC. 3104. INCREASE IN BENEFITS STARTING 20 YEARS**
 14 **AFTER INITIAL ELIGIBILITY.**

15 (a) IN GENERAL.—Section 215 of the Social Security
 16 Act (42 U.S.C. 415), as amended by this Act, is amended
 17 by adding at the end the following new subsection:

18 “Increased Monthly Insurance Benefit After 20 Years of
 19 Initial Eligibility

20 “(k)(1) Notwithstanding the preceding provisions of
 21 this section, in the case of an individual who is a 20-year
 22 beneficiary, the primary insurance amount of the indi-
 23 vidual (as determined before the application of this sub-
 24 section) shall be increased for months beginning with the
 25 first month for which the individual attains such status

1 by the amount equal to the applicable percentage of the
2 applicable average primary insurance amount.

3 “(2) For purposes of this subsection, the term ‘20-
4 year beneficiary’ means an individual who has been eligible
5 for old-age insurance benefits or disability insurance bene-
6 fits under this title for at least 240 months.

7 “(3) For purposes of paragraph (1), the term ‘appli-
8 cable average primary insurance amount’ means, with re-
9 spect to a 20-year beneficiary, the primary insurance
10 amount determined by the Commissioner of Social Secu-
11 rity that would apply to an individual of the same age as
12 the age at which the 20-year beneficiary first attains such
13 status, if the individual had earnings for each calendar
14 year in which the individual would have attained ages 20
15 through the year prior to the age of eligibility, respectively,
16 equal to the national average earnings for all such individ-
17 uals for each such year.

18 “(4) For purposes of paragraph (1), the applicable
19 percentage is—

20 “(A) for each month occurring during the first
21 12-month period for which an individual is a 20-year
22 beneficiary, 1 percent;

23 “(B) for each month occurring during the sec-
24 ond 12-month period for which an individual is such
25 a beneficiary, 2 percent;

1 “(C) for each month occurring during the third
 2 12-month period for which an individual is such a
 3 beneficiary, 3 percent;

4 “(D) for each month occurring during the
 5 fourth 12-month period for which an individual is
 6 such a beneficiary, 4 percent; and

7 “(E) for each month occurring thereafter, 5
 8 percent.”.

9 (b) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to benefits payable for months be-
 11 ginning after December 31, 2013.

12 **SEC. 3105. ADJUSTMENT TO NORMAL AND EARLY RETIRE-**
 13 **MENT AGES.**

14 Section 216(l) of the Social Security Act (42 U.S.C.
 15 416(l)) is amended—

16 (1) in paragraph (1)—

17 (A) in subparagraph (D), by striking “;
 18 and” and inserting a semicolon; and

19 (B) by striking subparagraph (E) and in-
 20 serting the following new subparagraphs:

21 “(E) with respect to an individual who at-
 22 tains early retirement age after December 31,
 23 2021, and before January 1, 2023, 67 years of
 24 age;

“(F) with respect to an individual who,
during the period after December 31, 2022,
and before January 1, 2070—

“(i) for purposes of paragraph
(2)(A)(ii), attains 62 years of age, such in-
dividual’s early retirement age plus 60
months; or

“(ii) attains early retirement age pur-
suant to paragraph (2)(B), 67 years plus
the number of months determined under
the age increase factor for the calendar
year in which such individual attains early
retirement age; and

“(G) with respect to an individual who—

“(i) for purposes of paragraph
(2)(A)(iii), attains 62 years of age after
December 31, 2069, 69 years of age; or

“(ii) attains early retirement age pur-
suant to paragraph (2)(B) after December
31, 2069, 69 years of age.”;

(2) by amending paragraph (2) to read as fol-
lows:

“(2) The term ‘early retirement age’ means—

“(A) in the case of an old-age, wife’s, or
husband’s insurance benefit—

1 “(i) 62 years of age with respect to an
2 individual who attains such age before
3 January 1, 2023;

4 “(ii) with respect to an individual who
5 attains 62 years of age after December 31,
6 2022, and before January 1, 2070, 62
7 years of age plus the number of months
8 determined under the age increase factor
9 for the calendar year in which such indi-
10 vidual attains 62 years of age; and

11 “(iii) with respect to an individual
12 who attains age 62 after December 31,
13 2069, 64 years of age; or

14 “(B) in the case of a widow’s or widower’s
15 insurance benefit, 60 years of age.”; and

16 (3) by adding at the end the following new
17 paragraph:

18 “(4) The age increase factor shall be equal to
19 $\frac{1}{24}$ of the number of months (rounded down to a
20 full month) in the period beginning with January
21 2023 and ending with December of the year in
22 which—

23 “(A) for purposes of paragraph (1)(F)(ii),
24 the individual attains 60 years of age; or

1 “(B) for purposes of paragraph (2)(A)(ii),
 2 the individual attains 62 years of age.”.

3 **SEC. 3106. APPLICATION OF ACTUARIAL REDUCTION FOR**
 4 **DISABLED BENEFICIARIES WHO ATTAIN**
 5 **EARLY RETIREMENT AGE.**

6 (a) IN GENERAL.—Section 202(k)(4) of the Social
 7 Security Act (42 U.S.C. 402(k)(4)) is amended to read
 8 as follows:

9 “(4)(A) Subject to subparagraph (B), any individual
 10 who, under this section and section 223, is entitled for
 11 any month to both an old-age insurance benefit and a dis-
 12 ability insurance benefit under this title shall be entitled
 13 to only the larger of such benefits for such month, except
 14 that, if such individual so elects, he shall instead be enti-
 15 tled to only the smaller of such benefits for such month.

16 “(B) An individual described in subparagraph (A)
 17 who has attained transitional retirement age (as deter-
 18 mined under subparagraph (C)) shall only be entitled to
 19 the old-age insurance benefit for such month, as reduced
 20 for such month pursuant to subsection (q)(1).

21 “(C) For purposes of subparagraph (B), the term
 22 ‘transitional retirement age’ means—

23 “(i) with respect to an individual who attains
 24 62 years of age before January 1, 2014, 66 years
 25 of age;

1 “(ii) with respect to an individual who attains
 2 62 years of age after December 31, 2013, and before
 3 January 1, 2025, 66 years of age reduced by the
 4 number of months determined under the transition
 5 factor (as determined under subparagraph (D)) for
 6 the calendar year in which such individual attains 62
 7 years of age; and

8 “(iii) with respect to an individual who attains
 9 62 years of age after December 31, 2024, 64 years
 10 of age.

11 “(D) For purposes of subparagraph (C)(ii), the tran-
 12 sition factor shall be equal to two-twelfths of the number
 13 of months in the period beginning with January 2014 and
 14 ending with December of the year in which the individual
 15 attains 62 years of age.”.

16 (b) CONFORMING AMENDMENTS.—

17 (1) PERIOD OF DISABILITY.—Clause (i) of sec-
 18 tion 216(i)(2)(D) of the Social Security Act (42
 19 U.S.C. 416(i)(2)(D)) is amended by striking “retire-
 20 ment age (as defined in subsection (l))” and insert-
 21 ing “transitional retirement age (as defined in sec-
 22 tion 216(k)(4))”.

23 (2) DISABILITY INSURANCE BENEFIT PAY-
 24 MENTS.—Section 223(a)(1) of the Social Security
 25 (42 U.S.C. 423(a)(1)) is amended—

1 (A) in subparagraph (B), by striking “re-
 2 tirement age (as defined in section 216(l))” and
 3 inserting “transitional retirement age (as de-
 4 fined in section 216(k)(4))”; and

5 (B) in the flush matter at the end, by
 6 striking “retirement age (as defined in section
 7 216(l))” and inserting “transitional retirement
 8 age (as defined in section 216(k)(4))”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to benefits payable for months be-
 11 ginning after December 31, 2013.

12 **SEC. 3107. OPTION TO COLLECT UP TO ONE-HALF OF OLD-**
 13 **AGE INSURANCE BENEFIT AT AGE 62.**

14 (a) IN GENERAL.—Section 202 of the Social Security
 15 Act (42 U.S.C. 402) is amended by adding at the end the
 16 following:

17 “Option To Collect up to One-Half of Old-Age Insurance
 18 Benefit Beginning at Age 62

19 “(z)(1) Not later than January 1, 2014, the Commis-
 20 sioner of Social Security shall establish an option, subject
 21 to such regulations as are prescribed by the Commissioner
 22 under paragraph (2), for a fully insured individual (as de-
 23 fined in section 214) to elect to receive a reduced monthly
 24 benefit after such individual attains 62 years of age, con-
 25 sisting of the following:

1 “(A) Subject to paragraph (3), for months be-
2 ginning with the month in which the individual at-
3 tains age 62, a monthly benefit equal to such per-
4 centage as is elected by the individual, but which
5 shall not be greater than 50 percent, of the primary
6 insurance amount determined for the individual at
7 age 62.

8 “(B) For months beginning with the month in
9 which the individual attains early retirement age, a
10 monthly benefit equal to the sum of—

11 “(i) the monthly benefit payable to the in-
12 dividual under subparagraph (A); and

13 “(ii) the amount equal to the applicable
14 percentage (as determined under subparagraph
15 (C)) of primary insurance amount determined
16 for the individual under section 215 for such
17 month (determined without regard to any elec-
18 tion under this subsection).

19 “(C) For purposes of subparagraph (B)(ii), the
20 applicable percentage shall be equal to the difference
21 between—

22 “(i) 100 percent; and

23 “(ii) the percentage elected by the indi-
24 vidual under subparagraph (A).

1 “(2) An individual shall elect the option under this
 2 subsection in accordance with regulations prescribed by
 3 the Commissioner of Social Security.

4 “(3) The monthly benefit payable to an individual
 5 under paragraph (1)(A) shall be subject to reduction as
 6 provided in subsection (q).”.

7 (b) CONFORMING AMENDMENT.—Section 202(a) of
 8 the Social Security Act (42 U.S.C. 402(a)) is amended
 9 in the last sentence, by striking “subsection (q) and sub-
 10 section (w)” and inserting “subsections (q), (w), and (z)”.

11 **SEC. 3108. COVERAGE OF NEWLY HIRED STATE AND LOCAL**
 12 **EMPLOYEES.**

13 (a) AMENDMENTS TO THE SOCIAL SECURITY ACT.—

14 (1) IN GENERAL.—Paragraph (7) of section
 15 210(a) of the Social Security Act (42 U.S.C.
 16 410(a)(7)) is amended to read as follows:

17 “(7) Excluded State or local government em-
 18 ployment (as defined in subsection (s));”.

19 (2) EXCLUDED STATE OR LOCAL GOVERNMENT
 20 EMPLOYMENT.—

21 (A) IN GENERAL.—Section 210 of such
 22 Act (42 U.S.C. 410) is amended by adding at
 23 the end the following new subsection:

24 “(s) EXCLUDED STATE OR LOCAL GOVERNMENT
 25 EMPLOYMENT.—(1) IN GENERAL.—The term ‘excluded

1 State or local government employment’ means any service
 2 performed in the employ of a State, of any political sub-
 3 division thereof, or of any instrumentality of any one or
 4 more of the foregoing which is wholly owned thereby, if—

5 “(A)(i) such service would be excluded from the
 6 term ‘employment’ for purposes of this title if the
 7 preceding provisions of this section as in effect in
 8 December 2020 had remained in effect, and (ii) the
 9 requirements of paragraph (2) are met with respect
 10 to such service, or

11 “(B) the requirements of paragraph (3) are met
 12 with respect to such service.

13 “(2) EXCEPTION FOR CURRENT EMPLOYMENT
 14 WHICH CONTINUES.—

15 “(A) IN GENERAL.—The requirements of this
 16 paragraph are met with respect to service for any
 17 employer if—

18 “(i) such service is performed by an indi-
 19 vidual—

20 “(I) who was performing substantial
 21 and regular service for remuneration for
 22 that employer before January 1, 2021,

23 “(II) who is a bona fide employee of
 24 that employer on December 31, 2020, and

1 “(III) whose employment relationship
 2 with that employer was not entered into
 3 for purposes of meeting the requirements
 4 of this subparagraph, and

5 “(ii) the employment relationship with that
 6 employer has not been terminated after Decem-
 7 ber 31, 2020.

8 “(B) TREATMENT OF MULTIPLE AGENCIES AND
 9 INSTRUMENTALITIES.—For purposes of subpara-
 10 graph (A), under regulations (consistent with regula-
 11 tions established under section 3121(t)(2)(B) of the
 12 Internal Revenue Code of 1986)—

13 “(i) all agencies and instrumentalities of a
 14 State (as defined in section 218(b)) or of the
 15 District of Columbia shall be treated as a single
 16 employer, and

17 “(ii) all agencies and instrumentalities of a
 18 political subdivision of a State (as so defined)
 19 shall be treated as a single employer and shall
 20 not be treated as described in clause (i).

21 “(3) EXCEPTION FOR CERTAIN SERVICES.—

22 “(A) IN GENERAL.—The requirements of this
 23 paragraph are met with respect to service if such
 24 service is performed—

1 “(i) by an individual who is employed by a
2 State or political subdivision thereof to relieve
3 such individual from unemployment,

4 “(ii) in a hospital, home, or other institu-
5 tion by a patient or inmate thereof as an em-
6 ployee of a State or political subdivision thereof
7 or of the District of Columbia,

8 “(iii) by an individual, as an employee of
9 a State or political subdivision thereof or of the
10 District of Columbia, serving on a temporary
11 basis in case of fire, storm, snow, earthquake,
12 flood, or other similar emergency,

13 “(iv) by any individual as an employee in-
14 cluded under section 5351(2) of title 5, United
15 States Code (relating to certain interns, student
16 nurses, and other student employees of hos-
17 pitals of the District of Columbia Government),
18 other than as a medical or dental intern or a
19 medical or dental resident in training,

20 “(v) by an election official or election
21 worker if the remuneration paid in a calendar
22 year for such service is less than \$1,000 with
23 respect to service performed during 2021, and
24 the adjusted amount determined under sub-
25 paragraph (C) for any subsequent year with re-

1 spect to service performed during such subse-
 2 quent year, except to the extent that service by
 3 such election official or election worker is in-
 4 cluded in employment under an agreement
 5 under section 218, or

6 “(vi) by an employee in a position com-
 7 pensated solely on a fee basis which is treated
 8 pursuant to section 211(c)(2)(E) as a trade or
 9 business for purposes of inclusion of such fees
 10 in net earnings from self-employment.

11 “(B) DEFINITIONS.—As used in this para-
 12 graph, the terms ‘State’ and ‘political subdivision’
 13 have the meanings given those terms in section
 14 218(b).

15 “(C) ADJUSTMENTS TO DOLLAR AMOUNT FOR
 16 ELECTION OFFICIALS AND ELECTION WORKERS.—
 17 For each year after 2021, the Commissioner of So-
 18 cial Security shall adjust the amount referred to in
 19 subparagraph (A)(v) at the same time and in the
 20 same manner as is provided under section
 21 215(a)(1)(B)(ii) with respect to the amounts re-
 22 ferred to in section 215(a)(1)(B)(i), except that—

23 “(i) for purposes of this subparagraph,
 24 2018 shall be substituted for the calendar year
 25 referred to in section 215(a)(1)(B)(ii)(II), and

1 “(ii) such amount as so adjusted, if not a
 2 multiple of \$100, shall be rounded to the next
 3 higher multiple of \$100 where such amount is
 4 a multiple of \$50 and to the nearest multiple
 5 of \$100 in any other case.

6 The Commissioner of Social Security shall determine and
 7 publish in the Federal Register each adjusted amount de-
 8 termined under this subparagraph not later than Novem-
 9 ber 1 preceding the year for which the adjustment is
 10 made.”.

11 (B) CONFORMING AMENDMENTS.—

12 (i) Subsection (k) of section 210 of
 13 such Act (42 U.S.C. 410(k)) (relating to
 14 covered transportation service) is repealed.

15 (ii) Section 210(p) of such Act (42
 16 U.S.C. 410(p)) is amended—

17 (I) in paragraph (2), by striking
 18 “service is performed” and all that
 19 follows and inserting “service is serv-
 20 ice described in subsection (s)(3)(A).”;
 21 and

22 (II) in paragraph (3)(A), by in-
 23 serting “under subsection (a)(7) as in
 24 effect in December 2020” after “sec-
 25 tion”.

1 (iii) Section 218(c)(6) of such Act (42
2 U.S.C. 418(c)(6)) is amended—

3 (I) by striking subparagraph (C);

4 (II) by redesignating subpara-
5 graphs (D) and (E) as subparagraphs
6 (C) and (D), respectively; and

7 (III) by striking subparagraph
8 (F) and inserting the following:

9 “(E) service which is included as employment
10 under section 210(a).”.

11 (b) AMENDMENTS TO THE INTERNAL REVENUE
12 CODE OF 1986.—

13 (1) IN GENERAL.—Paragraph (7) of section
14 3121(b) of the Internal Revenue Code of 1986 (re-
15 lating to employment) is amended to read as follows:

16 “(7) excluded State or local government em-
17 ployment (as defined in subsection (t));”.

18 (2) EXCLUDED STATE OR LOCAL GOVERNMENT
19 EMPLOYMENT.—Section 3121 of such Code is
20 amended by inserting after subsection (s) the fol-
21 lowing new subsection:

22 “(t) EXCLUDED STATE OR LOCAL GOVERNMENT EM-
23 PLOYMENT.—

24 “(1) IN GENERAL.—For purposes of this chap-
25 ter, the term ‘excluded State or local government

1 employment’ means any service performed in the
 2 employ of a State, of any political subdivision there-
 3 of, or of any instrumentality of any one or more of
 4 the foregoing which is wholly owned thereby, if—

5 “(A)(i) such service would be excluded
 6 from the term ‘employment’ for purposes of this
 7 chapter if the provisions of subsection (b)(7) as
 8 in effect in December 2020 had remained in ef-
 9 fect, and (ii) the requirements of paragraph (2)
 10 are met with respect to such service, or

11 “(B) the requirements of paragraph (3)
 12 are met with respect to such service.

13 “(2) EXCEPTION FOR CURRENT EMPLOYMENT
 14 WHICH CONTINUES.—

15 “(A) IN GENERAL.—The requirements of
 16 this paragraph are met with respect to service
 17 for any employer if—

18 “(i) such service is performed by an
 19 individual—

20 “(I) who was performing sub-
 21 stantial and regular service for remu-
 22 neration for that employer before Jan-
 23 uary 1, 2021,

1 “(II) who is a bona fide employee
2 of that employer on December 31,
3 2020, and

4 “(III) whose employment rela-
5 tionship with that employer was not
6 entered into for purposes of meeting
7 the requirements of this subpara-
8 graph, and

9 “(ii) the employment relationship with
10 that employer has not been terminated
11 after December 31, 2020.

12 “(B) TREATMENT OF MULTIPLE AGENCIES
13 AND INSTRUMENTALITIES.—For purposes of
14 subparagraph (A), under regulations—

15 “(i) all agencies and instrumentalities
16 of a State (as defined in section 218(b) of
17 the Social Security Act) or of the District
18 of Columbia shall be treated as a single
19 employer, and

20 “(ii) all agencies and instrumentalities
21 of a political subdivision of a State (as so
22 defined) shall be treated as a single em-
23 ployer and shall not be treated as de-
24 scribed in clause (i).

25 “(3) EXCEPTION FOR CERTAIN SERVICES.—

1 “(A) IN GENERAL.—The requirements of
2 this paragraph are met with respect to service
3 if such service is performed—

4 “(i) by an individual who is employed
5 by a State or political subdivision thereof
6 to relieve such individual from unemploy-
7 ment,

8 “(ii) in a hospital, home, or other in-
9 stitution by a patient or inmate thereof as
10 an employee of a State or political subdivi-
11 sion thereof or of the District of Columbia,

12 “(iii) by an individual, as an employee
13 of a State or political subdivision thereof
14 or of the District of Columbia, serving on
15 a temporary basis in case of fire, storm,
16 snow, earthquake, flood, or other similar
17 emergency,

18 “(iv) by any individual as an employee
19 included under section 5351(2) of title 5,
20 United States Code (relating to certain in-
21 terns, student nurses, and other student
22 employees of hospitals of the District of
23 Columbia Government), other than as a
24 medical or dental intern or a medical or
25 dental resident in training,

1 “(v) by an election official or election
 2 worker if the remuneration paid in a cal-
 3 endar year for such service is less than
 4 \$1,000 with respect to service performed
 5 during 2021, and the adjusted amount de-
 6 termined under section 210(s)(3)(C) of the
 7 Social Security Act for any subsequent
 8 year with respect to service performed dur-
 9 ing such subsequent year, except to the ex-
 10 tent that service by such election official or
 11 election worker is included in employment
 12 under an agreement under section 218 of
 13 the Social Security Act, or

14 “(vi) by an employee in a position
 15 compensated solely on a fee basis which is
 16 treated pursuant to section 1402(c)(2)(E)
 17 as a trade or business for purposes of in-
 18 clusion of such fees in net earnings from
 19 self-employment.

20 “(B) DEFINITIONS.—As used in this para-
 21 graph, the terms ‘State’ and ‘political subdivi-
 22 sion’ have the meanings given those terms in
 23 section 218(b) of the Social Security Act.”.

24 (3) CONFORMING AMENDMENTS.—

1 (A) Subsection (j) of such section 3121
2 (relating to covered transportation service) is
3 repealed.

4 (B) Paragraph (2) of section 3121(u) of
5 such Code (relating to application of hospital
6 insurance tax to Federal, State, and local em-
7 ployment) is amended—

8 (i) in subparagraph (B), by striking
9 “service is performed” in clause (ii) and all
10 that follows through the end of such sub-
11 paragraph and inserting “service is service
12 described in subsection (t)(3)(A).”; and

13 (ii) in subparagraph (C)(i), by insert-
14 ing “under subsection (b)(7) as in effect in
15 December 2020” after “chapter”.

16 (c) EFFECTIVE DATE.—Except as otherwise provided
17 in this section, the amendments made by this section shall
18 apply with respect to service performed after December
19 31, 2020.

1 **SEC. 3109. INCLUSION IN ANNUAL SOCIAL SECURITY AC-**
2 **COUNT STATEMENT OF ESTIMATED PRESENT**
3 **VALUE OF TAXES AND BENEFITS FOR SOCIAL**
4 **SECURITY AND MEDICARE AND PROJECTED**
5 **DEFICIT AS A PERCENT OF LIFETIME EARN-**
6 **INGS.**

7 (a) IN GENERAL.—Section 1143(a)(2) of the Social
8 Security Act (42 U.S.C. 1320b–13(a)(2)) is amended—

9 (1) in subparagraph (E), by striking “benefits.”
10 and inserting “benefits;”; and

11 (2) by adding after subparagraph (E) the fol-
12 lowing new subparagraphs:

13 “(F) an estimate, as determined by the Com-
14 missioner, in consultation with the Secretary of
15 Health and Human Services, on the basis of avail-
16 able records of the Commissioner and projections
17 based on reasonable assumptions, of—

18 “(i) the present value of potential lifetime
19 aggregate employer, employee, and self-employ-
20 ment contributions of the eligible individual for
21 old-age, survivors, and disability insurance
22 (under title II) and for hospital insurance
23 (under part A of title XVIII);

24 “(ii) the present value of potential lifetime
25 premiums payable (under parts B and D of title
26 XVIII); and

1 “(iii) the present value of potential lifetime
 2 aggregate retirement, disability, survivor, and
 3 auxiliary benefits payable on the eligible individ-
 4 ual’s account under title II and per capita bene-
 5 fits payable under the Medicare program of title
 6 XVIII; and

7 “(G) an estimate, as determined by the Com-
 8 missioner, in consultation with the Secretary of
 9 Health and Human Services, on the basis of avail-
 10 able records of the Commissioner and projections
 11 based on reasonable assumptions, of the ratio (ex-
 12 pressed as a percentage) of—

13 “(i) the sum of the projected deficit-fi-
 14 nanced benefits under the old-age, survivors,
 15 and disability insurance program with respect
 16 to the eligible individual and the projected def-
 17 icit-financed benefits under part A of the Medi-
 18 care program under title XVIII with respect to
 19 the eligible individual, to

20 “(ii) projected lifetime earnings of the eli-
 21 gible individual.”.

22 (b) DEFINITIONS.—Section 1143(a) of such Act (42
 23 U.S.C. 1320b–13(a)) is amended—

24 (1) by redesignating paragraph (3) as para-
 25 graph (4); and

1 (2) by inserting after paragraph (2) the fol-
 2 lowing new paragraph:

3 “(3) For purposes of paragraph (2)(G)—

4 “(A) The term ‘projected deficit-financed bene-
 5 fits’ means—

6 “(i) with respect to an eligible individual in
 7 connection with the old-age, survivors, and dis-
 8 ability insurance program, the product of—

9 “(I) the benefits described in subpara-
 10 graph (F)(ii) of such individual under such
 11 program, and

12 “(II) the ratio of future annual defi-
 13 cits, excluding interest, of the Federal Old-
 14 Age and Survivors Insurance Trust Fund
 15 and the Federal Disability Insurance Trust
 16 Fund over the eligible individual’s lifetime
 17 to future annual outlays from such Trust
 18 Funds over such lifetime; and

19 “(ii) with respect to an eligible individual
 20 in connection with the Medicare program under
 21 title XVIII, the product of—

22 “(I) the benefits for hospital insur-
 23 ance (under part A of title XVIII) de-
 24 scribed in subparagraph (F)(ii) of such in-
 25 dividual under such program, and

1 “(II) the ratio of future annual defi-
2 cits of the Federal Hospital Insurance
3 Trust Fund over the eligible individual’s
4 lifetime to future annual outlays from such
5 Trust Fund over such lifetime.

6 “(B) The term ‘projected lifetime earnings’ of
7 the eligible individual means the present value of the
8 potential total wages paid to, and self-employment
9 income derived by, the eligible individual over the eli-
10 gible individual’s lifetime, as determined without re-
11 gard to the contribution and benefit base under sec-
12 tion 230.”.

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply with respect to annual statements
15 issued after 2013.

16 **SEC. 3110. RETIREMENT INFORMATION CAMPAIGN.**

17 The Commissioner of Social Security shall establish
18 a public information campaign to provide information and
19 education regarding the implications on personal financial
20 security of early and other retirement decisions and the
21 need for greater retirement savings. The information cam-
22 paign should be designed to encourage individuals to delay
23 retirement so as to build enhanced levels of social security
24 benefits and personal retirement savings. To the extent
25 the Commissioner of Social Security determines appro-

1 priate, the information provided through the campaign
 2 should utilize behavioral economics approaches, such as
 3 structured choice, and other scientific approaches.

4 **TITLE IV—CONVERSION TO** 5 **CHAINED CPI**

6 **SEC. 4101. CONVERSION TO CHAINED CPI.**

7 (a) CONSUMER PRICE INDEX ADJUSTMENTS APPLI-
 8 CABLE TO THE INTERNAL REVENUE CODE PROVI-
 9 SIONS.—

10 (1) IN GENERAL.—Paragraph (3) of section
 11 1(f) of the Internal Revenue Code of 1986 is amend-
 12 ed to read as follows:

13 “(3) COST-OF-LIVING ADJUSTMENT.—

14 “(A) IN GENERAL.—For purposes of para-
 15 graph (2), the cost-of-living adjustment for any
 16 calendar year is—

17 “(i) for adjustments first beginning
 18 before 2014, the product of—

19 “(I) the CPI fraction for cal-
 20 endar years before 2014, multiplied
 21 by

22 “(II) the Chained CPI fraction
 23 for calendar years after 2013,
 24 reduced by 1, and

1 “(ii) for adjustments first beginning
 2 after 2013, the Chained CPI fraction for
 3 years after 2013.

4 “(B) CPI FRACTION FOR CALENDAR
 5 YEARS BEFORE 2014.—The CPI fraction for cal-
 6 endar years before 2014 is the fraction—

7 “(i) the numerator of which is the
 8 CPI for the calendar year 2012; and

9 “(ii) the denominator of which is the
 10 CPI for the calendar year 1992.

11 “(C) CHAINED CPI FRACTION FOR CAL-
 12 ENDAR YEARS AFTER 2013.—The Chained CPI
 13 fraction for calendar years after 2013 is the
 14 fraction—

15 “(i) the numerator of which is the
 16 Chained CPI for the preceding calendar
 17 year, and

18 “(ii) the denominator of which is the
 19 Chained CPI for the calendar year 2012.”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) Paragraph (4) of section 1(f) of such
 22 Code is amended to read as follows:

23 “(4) CPI AND CHAINED CPI FOR ANY CAL-
 24 ENDAR YEAR.—For purposes of paragraph (3)—

1 “(A) CPI.—The CPI for any calendar year
2 is the average of the Consumer Price Index as
3 of the close of the 12-month period ending on
4 August 31 of such calendar year.

5 “(B) CHAINED CPI.—The Chained CPI for
6 any calendar year is the average of the Chained
7 Consumer Price Index as of the close of the 12-
8 month period ending on August 31 of such cal-
9 endar year.”.

10 (B) Paragraph (5) of section 1(f) of such
11 Code is amended to read as follows:

12 “(5) CONSUMER PRICE INDEX AND CHAINED
13 CONSUMER PRICE INDEX.—For purposes of para-
14 graph (4)—

15 “(A) CONSUMER PRICE INDEX.—The term
16 ‘Consumer Price Index’ means the last Con-
17 sumer Price Index for all urban consumers pub-
18 lished by the Department of Labor. For pur-
19 poses of the preceding sentence, the revision of
20 the Consumer Price Index which is most con-
21 sistent with the Consumer Price Index for cal-
22 endar year 1986 shall be used.

23 “(B) CHAINED CONSUMER PRICE INDEX.—
24 The term ‘Chained Consumer Price Index’
25 means the most recent estimate of the Chained

1 Consumer Price Index for all urban consumers
2 published by the Department of Labor.”.

3 (C) Subclause (II) of section
4 36B(b)(3)(A)(ii) of such Code is amended by
5 striking “consumer price index” and inserting
6 “Chained Consumer Price Index (as defined in
7 section 1(f)(5)(B))”.

8 (D) Subclause (II) of section
9 36B(f)(2)(B)(ii) of such Code is amended by
10 striking “by substituting ‘calendar year 2013’
11 for ‘calendar year 1992’ in subparagraph (B)
12 thereof” and inserting “by substituting ‘cal-
13 endar year 2013’ for ‘calendar year 2012’ in
14 subparagraph (C) thereof”.

15 (E) Clause (ii) of section 45R(d)(3)(B) of
16 such Code is amended by striking “determined
17 by substituting ‘calendar year 2012’ for ‘cal-
18 endar year 1992’ in subparagraph (B) thereof”.

19 (F) Subparagraph (B) of section 125(i)(2)
20 of such Code is amended by striking “deter-
21 mined by substituting ‘calendar year 2012’ for
22 ‘calendar year 1992’ in subparagraph (B)
23 thereof”.

24 (G) Subclause (II) of section
25 4980I(b)(3)(C)(v) of such Code is amended by

1 striking “for ‘1992’ in subparagraph (B) there-
 2 of” and inserting “for ‘2012’ in subparagraph
 3 (C) thereof”.

4 (H) Clause (ii) of section 5000A(c)(3)(D)
 5 of such Code is amended by striking “by sub-
 6 stituting ‘calendar year 2015’ for ‘calendar year
 7 1992’ in subparagraph (B) thereof” and insert-
 8 ing “by substituting ‘calendar year 2015’ for
 9 ‘calendar year 2012’ in subparagraph (C) there-
 10 of”.

11 (3) EFFECTIVE DATE.—The amendments made
 12 by this subsection shall apply to taxable years begin-
 13 ning after December 31, 2013.

14 (b) MODIFICATIONS TO COST-OF-LIVING INDEX-
 15 ATION OF SOCIAL SECURITY BENEFITS.—

16 (1) IN GENERAL.—Section 215(i)(1)(D) of the
 17 Social Security Act (42 U.S.C. 415(i)(1)(D)) is
 18 amended to read as follows:

19 “(D) the term ‘CPI increase percentage’, with
 20 respect to a base quarter or cost-of-living computa-
 21 tion quarter in any calendar year, means the per-
 22 centage (rounded to the nearest one-tenth of 1 per-
 23 cent) by which the Chained Consumer Price Index
 24 for All Urban Consumers (as published in its initial
 25 form by the Bureau of Labor Statistics of the De-

partment of Labor) for such base quarter or cost-of-living computation quarter exceeds such index for the later of—

“(i) the most recent calendar quarter (prior to such base quarter or cost-of-living computation quarter) which was a base quarter under subparagraph (A)(ii); or

“(ii) the most recent cost-of-living computation quarter under subparagraph (B);”.

(2) DEFINITIONS.—Section 215(i)(1)(G) of such Act (42 U.S.C. 415(i)(1)(G)) is amended to read as follows:

“(G) the Chained Consumer Price Index for All Urban Consumers for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index (as published in its initial form by the Bureau of Labor Statistics of the Department of Labor as of the end of such quarter) for the 12-month period ending with such quarter.”.

(3) CONFORMING CHANGES FOR PRE-1977 LAW.—

(A) Section 215(i)(1) of such Act, as in effect in December 1978, and as applied in cer-

tain cases under the provisions of such Act as
in effect after December 1978, is amended—

(i) in subparagraph (B), by striking
“and” after the semicolon;

(ii) in subparagraph (C), by striking
“for the 3 months in such quarter.” and
inserting “for the 12 months in the 12-
month period ending with such quarter;
and”; and

(iii) by adding at the end the fol-
lowing new subparagraph:

“(D) the term ‘Consumer Price Index’ means
the Chained Consumer Price Index for All Urban
Consumers (C-CPI-U), as published in its initial
form by the Bureau of Labor Statistics of the De-
partment of Labor.”.

(B) Section 215(i)(4) of the Social Secu-
rity Act (42 U.S.C. 415(i)(4)) is amended by
inserting “and by section 4101(b) of the The
Dollar for Dollar Act of 2012” after “1986,”.

(4) EFFECTIVE DATE.—The amendments made
by this subsection shall apply with respect to in-
creases described in section 215(i) of the Social Se-
curity Act, and to increases under programs depend-
ent on Social Security cost-of-living adjustments, ef-

1 fective with the month of December for years after
2 2012.

3 (c) ADJUSTMENTS OF PROVISIONS UTILIZING THE
4 CONSUMER PRICE INDEX.—

5 (1) IN GENERAL.—Notwithstanding any other
6 provision of law, and except as provided in this sec-
7 tion, for purposes of determining the amount of any
8 cost-of-living increase or similar adjustment under a
9 Federal program or law effective in the month of
10 December 2013 and thereafter, any such increase
11 for the period for which the percentage change is de-
12 termined shall be deemed to be, in lieu of the in-
13 crease otherwise determined under applicable law,
14 the increase determined under such applicable law
15 by substituting the Chained CPI for the CPI.

16 (2) INCREASES DETERMINED FROM A CON-
17 STANT BASE YEAR.—

18 (A) IN GENERAL.—In any case in which
19 the amount of a cost-of-living increase effective
20 in the month of December 2012 and thereafter
21 is determined under applicable law by reference
22 to a change in the CPI over a period which is
23 determined by reference to a base period which
24 remains constant from year to year, any such
25 increase for any period shall be deemed to be,

1 in lieu of the increase otherwise determined
2 under applicable law, the increase, expressed as
3 a percentage increase, equal to the product of—

4 (i) the CPI fraction prior to 2014;
5 multiplied by

6 (ii) the Chained CPI fraction after
7 2013,

8 reduced by 1.

9 (B) CPI FRACTION PRIOR TO 2014.—The
10 CPI fraction prior to 2014 is the fraction—

11 (i) the numerator of which is the CPI
12 for the period, ending with or during 2012,
13 which corresponds to the base period; and

14 (ii) the denominator of which is the
15 CPI for the base period.

16 (C) CHAINED CPI FRACTION AFTER 2013.—
17 The Chained CPI fraction after 2013 is the
18 fraction—

19 (i) the numerator of which is the
20 Chained CPI for the period, ending with or
21 during the year preceding the year in
22 which the determination takes effect, which
23 corresponds to the base period; and

24 (ii) the denominator of which is the
25 most recently published estimate of the

1 Chained CPI for the period, ending with or
2 during 2012, which corresponds to the
3 base period.

4 (3) SPECIAL PROVISIONS AND EXCEPTIONS.—

5 (A) PROGRAMS TIED TO SOCIAL SECUR-
6 RITY.—Subject to subparagraph (B) and the ef-
7 fective date under subsection (b)(4), this section
8 and the amendments made by this section shall
9 apply to any cost-of-living increase or other ad-
10 justment which is determined by reference to an
11 adjustment made under section 215(i) of the
12 Social Security Act (42 U.S.C. 415(i)).

13 (B) POVERTY LINE.—This subsection shall
14 apply to revisions to the poverty line made pur-
15 suant to 42 U.S.C. 9902(2), and any programs
16 for which adjustments or eligibility thresholds
17 are based upon the poverty line as defined in
18 that section.

19 (4) CPI AND CHAINED CPI.—For purposes of
20 this subsection—

21 (A) the CPI for any period means the av-
22 erage monthly Consumer Price Index for such
23 period, or a component thereof, as determined
24 under the applicable law in connection with any
25 cost-of-living increase or similar adjustment re-

quired for such period (without regard to this subsection); and

(B) the Chained CPI for any period means, except as provided in paragraph (2)(C)(ii), the Chained Consumer Price Index for all urban consumers (as published in its initial form by the Bureau of Labor Statistics of the Department of Labor) for such period, or a component thereof, determined under applicable law in the same manner as the CPI for such period would be determined.

(d) CHANGE TO 12-MONTH PERIOD FOR COST-OF-LIVING INDEXATION FOR FEDERAL CIVIL SERVICE AND MILITARY RETIREMENT PROGRAMS.—

(1) IN GENERAL.—

(A) FEDERAL CIVIL SERVICE.—Sections 8340(a)(2) and 8462(a)(2) of title 5, United States Code, are each amended by striking “3 months comprising such quarter” and inserting “12-month period ending with such quarter”.

(B) MILITARY.—Section 1401a(h) of title 10, United States Code, is amended by striking “three months comprising that quarter” and inserting “12-month period ending with such quarter”.

1 (2) EFFECTIVE DATE.—The amendments made
 2 by this subsection shall apply with respect to cost-
 3 of-living increases effective with the month of De-
 4 cember of years after 2012.

5 **TITLE V—PUBLIC DEBT LIMIT**

6 **SEC. 5101. INCREASE IN PUBLIC DEBT LIMIT.**

7 Section 3101 of title 31, United States Code, is
 8 amended—

9 (1) in subsection (b)—

10 (A) by inserting “the sum of” after “shall
 11 not be more than”, and

12 (B) by inserting “the amount determined
 13 under subsection (d)” before “, outstanding at
 14 one time”, and

15 (2) by adding at the end the following new sub-
 16 section:

17 “(d) ADDITIONAL INCREASE.—The amount deter-
 18 mined under this subsection is the amount of spending
 19 reduction attributable to the The Dollar for Dollar Act
 20 of 2012, as estimated by the Office of Management and
 21 Budget.”.

○