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

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''The Dollar for Dollar Act of 2012''.

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

TITLE I—MEDICAID

SEC. 1101. COMPREHENSIVE MEDICAID WAIVERS.

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

''(g) COMPREHENSIVE MEDICAID WAIVERS.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—A State may elect to provide medical assistance under title XIX, directly or by contract, to eligible individuals pursuant to a comprehensive Medicaid waiver under this subsection in lieu of providing such assistance under a State plan approved under title XIX or a waiver approved under subsection (d) or extended under subsection (e). A State shall make such an election by submitting a waiver application to the Secretary for certifi-

cation that the application satisfies the requirements of paragraph (2).

''(B) WAIVER OF STATE MEDICAID PROGRAM REQUIREMENTS.—Any requirements applicable under this title or title XIX that would prevent a State from carrying out a comprehensive Medicaid waiver in accordance with the State's certified application and the requirements of this subsection are deemed waived.

''(C) SHARED SAVINGS BONUS.—A State conducting a comprehensive Medicaid waiver under this subsection shall be eligible for a shared savings bonus in accordance with paragraph (4).

''(D) OPTION TO INCLUDE CHIP-ELIGIBLE INDIVIDUALS.—A State may elect to treat individuals eligible for child health assistance under the State child health plan under title XXI as eligible individuals under a comprehensive Medicaid waiver. The waiver application and determination of the aggregate spending cap for the State for the waiver period shall take into account the inclusion of such individuals in the comprehensive Medicaid waiver. Any requirements applicable under this title, title XIX, or

title XXI that would prevent a State from including such individuals in the comprehensive Medicaid waiver in accordance with the State's certified application and the requirements of this subsection are deemed waived.

"(2) COMPREHENSIVE MEDICAID WAIVER APPLICATION.—An application for a comprehensive Medicaid waiver under this subsection shall contain the following:

"(A) GENERAL DESCRIPTION OF PROPOSED BENEFIT DELIVERY MODELS, ELIGIBILITY CRITERIA, AND BENEFITS.—A brief description, which may be in outline form, of the eligibility criteria and medical assistance to be provided that includes the methods for delivery of such assistance, the criteria for the determination of eligibility for such assistance, and the amount, duration, and scope of such assistance, including a description of the amount (if any) of premiums, deductibles, coinsurance, or other cost-sharing.

"(B) HEDIS MEASURES TO EVALUATE PERFORMANCE.—

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

Healthcare Effectiveness Data and Information Set (HEDIS) measures established by the National Committee for Quality Assurance selected by the State to annually evaluate the quality and cost-effectiveness of the medical assistance provided under the waiver, and for each such measure (and, if applicable, the distinct rates associated with the measure), the baseline data and the target performance goal applicable for each such measure or rate. The State shall select HEDIS measures that are closely aligned with the health care items and services that are provided to eligible individuals as medical assistance under the waiver.

''(ii) EVALUATION.—The description under this subparagraph shall specify the independent entity that the State will use to evaluate the waiver. The State shall provide an assurance that the State will submit a copy of the annual evaluation to the Secretary.

''(C) PROGRAM INTEGRITY.—A brief description of the State's program to prevent waste, fraud, and abuse under the waiver.

''(D) AGGREGATE SPENDING CAP.—An assurance that the State agrees—

''(i) to establish categories that accurately account for each of the distinct population groups that will qualify as eligible individuals under the waiver (such as children, parents, pregnant women, and the blind or disabled) based on such criteria as are determined appropriate by the State (referred to in this subsection as a 'population category');

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

''(iii) with respect to each period for which the waiver is approved, to not receive any Federal payments from the Secretary for amounts expended during such period that exceed the aggregate spending cap.

''(3) DETERMINATION OF AGGREGATE SPENDING CAP.—

''(A) ESTABLISHMENT OF SPENDING TEMPLATE.—

''(i) IN GENERAL.—The Secretary, in coordination with the Director of the Office of Management and Budget (referred to in this subsection as the 'Director'), shall establish a template for determining, with respect to each State, the aggregate spending cap for each period for which the State conducts a comprehensive Medicaid waiver under this subsection. The Secretary shall—

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

''(II) provide for a period for public comment on the proposed template; and

''(III) promulgate a final template not later than 120 days after such date of enactment.

''(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—

"(I) the total amount of Federal payments that would otherwise be made to the State during the waiver period with respect to any disproportionate share payment adjustment made under section 1923; and

"(II) the sum of the amounts determined under clause (iii) for each population category.

"(iii) PROJECTED FEDERAL PAYMENTS FOR MEDICAL ASSISTANCE PROVIDED TO POPULATION CATEGORIES.—For purposes of clause (ii)(II), the Secretary and the Director shall calculate the amount of projected expenditures for the provision of medical assistance to eligible individuals in each population category during the waiver period (as determined based upon the population categories established and the data provided by the State pursuant to paragraph (2)(D), as well as the annual baseline estimates supplied by the Director and such other data as is determined appropriate by the Sec-

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

"(I) subject to clause (iv), the monthly per capita amount of Federal payments that were made to the State under the State plan under title XIX (or under a waiver approved under subsection (d) or extended under subsection (e)) for an individual in such population category during the fiscal year prior to the State application for the waiver (referred to in this paragraph as the 'population category per capita baseline');

"(II) the number of individuals within such population category that are projected to be eligible to receive medical assistance during the waiver period; and

"(III) the number of months in the waiver period.

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

data to calculate the population category per capita baseline and that consists of individuals for which the State would otherwise be required to provide medical assistance to pursuant to section 1902(a)(10)(A)(i)(VIII), the population category per capita baseline shall be equal to the monthly per capita amount of Federal payments that would otherwise have been made to the State under the State plan under title XIX (or under a waiver approved under subsection (d) or extended under subsection (e)) during the preceding fiscal year for an individual who is under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII.

"(v) BUDGET NEUTRALITY.—In no event shall the aggregate spending cap established for a State for a waiver period allow for Federal payments to the State during the waiver period that exceed the amount of Federal payments to the State 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

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

"(C) DETERMINATION OF WAIVER SAVINGS.—The Secretary and the Director shall establish a process for determining with respect to a State and a waiver period the amount of savings achieved by a State for the period. The process shall take into account the difference between the aggregate spending cap applicable to the State for the waiver period and the total amount expended by the State under the waiver for the period.

"(D) PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary shall make annual payments under this paragraph on the basis of claims submitted by the State for expenses paid by the State for medical assistance provided under the waiver, and such other investigation as the Secretary or the Director may find necessary, and may reduce or increase the payments as necessary to adjust for prior overpayments or under payments under this paragraph.

"(5) DURATION.—

"(A) IN GENERAL.—A State shall conduct 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

the application as satisfying the requirements of paragraph (2).

''(ii) INQUIRIES.—The Secretary and the Director may submit a single set of inquiries for additional information to the State during the initial 90-day period described under clause (i). If a State receives a set of inquires, the State shall have up to 60 days to respond. The Secretary and the Director shall have an additional 30-day period, starting on the date the Secretary receives a State response to a set of inquiries, to make a final determination as to whether the State's waiver application may be certified as complying with the requirements of paragraph (2).

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

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

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

''(B) DENIAL OF WAIVER APPLICATIONS OR RENEWAL REQUESTS.—

''(i) IN GENERAL.—If the Secretary and the Director determine that an application for a comprehensive Medicaid waiver, or a request for extension of an existing comprehensive Medicaid waiver, does not satisfy the requirements of paragraph (2), the Secretary shall notify the State of the disapproval by written notification, not later than 10 days following the issuance of such determination and shall provide a detailed description of the reasons for the denial of the waiver to—

''(I) the State that submitted the waiver application or extension request;

''(II) the members of Congress representing such State; and

''(III) the Committee on Finance of the Senate and the Committee on

Energy and Commerce of the House of Representatives.

''(ii) ADMINISTRATIVE AND JUDICIAL REVIEW.—

''(I) ADMINISTRATIVE REVIEW.—Within 60 days after the date that a State receives notice of the denial of a waiver application or extension request, the State may appeal the determination to the Departmental Appeals Board established in the Department of Health and Human Services. The Departmental Appeals Board shall make a final determination with respect to an appeal filed under this subparagraph not less than 60 days after the date on which the appeal is filed.

''(II) JUDICIAL REVIEW.—Within 60 days after the date of a final decision by the Board under subclause (I) that is adverse to a State, the State may obtain judicial review of the final decision by filing an action in the district court of the United States for

the judicial district in which the principal or headquarters office of the State agency responsible for administering the State Medicaid program is located or the United States District Court for the District of Columbia.

''(C) REPORTS.—

''(i) IN GENERAL.—Not later than 2 years after the date on which the Secretary and the Director first approve an application for a comprehensive Medicaid waiver under this subsection and every 3 years thereafter, the Comptroller General of the United States (referred to in this subparagraph as the 'Comptroller') shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the waivers certified as of the date of such report. Each report shall include an evaluation of the quality and cost-effectiveness of the comprehensive Medicaid waivers in effect during the reporting period in providing medical assistance to

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

"(ii) REPORTING OF INFORMATION.—A State with a comprehensive Medicaid waiver under this subsection shall provide the Comptroller, in such form and manner as the Comptroller may require, with any relevant information regarding the waiver, including total expenditures by the State under the waiver, the number of individuals provided medical assistance under the waiver, and such other information as the Comptroller may require for purposes of preparing the reports required under this subparagraph.

"(7) NON-APPLICATIONS.—A comprehensive Medicaid waiver shall not apply to—

"(A) the pediatric vaccine program under section 1928; and

"(B) limitations on total payments to territories under section 1108.

"(8) OUTREACH AND EDUCATION.—

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

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

''(B) PUBLIC NOTICE AND COMMENT.—Before submitting an application for a comprehensive Medicaid waiver, a State shall make the proposed application available to the public through such means as the State determines appropriate and allow for a reasonable public comment period of not greater than 30 days.

''(C) PUBLIC AWARENESS OF APPROVED WAIVER.—A State that has been certified for a comprehensive Medicaid waiver shall conduct an outreach and education campaign to ensure that health care providers and eligible individuals within the State are provided with adequate notice regarding the methods and criteria through which the State intends to provide medical assistance under the waiver.

''(9) DEFINITIONS.—In this subsection:

''(A) AVERAGE MONTHLY UNEMPLOYMENT RATE.—The term 'average monthly unemployment rate' means the average of the monthly 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-

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

''(C) MEDICAL ASSISTANCE.—The term 'medical assistance' means—

''(i) health care coverage (as determined by the State); and

''(ii) rehabilitation and other services to help eligible individuals attain or retain capability for independence or self-care, such as home and community-based services.

''(D) STATE MEDICAID PROGRAM.—The term 'State Medicaid program' means the State program for medical assistance provided under a State plan under title XIX, including any waiver that has been approved with respect to a State plan prior to an application by the State for a comprehensive Medicaid waiver under this subsection.''.

SEC. 1102. PHASED-IN ELIMINATION OF ALLOWABLE PROVIDER TAXES UNDER MEDICAID.

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

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

''(I) for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, '5.5 percent' shall be substituted for '6 percent' each place it appears;

''(II) for fiscal years 2012 and 2013, the percentage specified under such paragraph shall apply;

''(III) for fiscal years 2014 through 2022, the percentage determined under clause (iii) for the fiscal year shall be substituted for '6 percent' each place it appears; and

''(IV) for fiscal year 2023 and each fiscal year thereafter, '0 percent' shall be substituted for '6 percent' each place it appears.

''(iii) For purposes of clause (ii)(III), the percentage determined under this clause shall be equal to the percentage applicable under subclause (II) or (III) of clause (ii) for the preceding fiscal year, reduced by 0.6 percentage points.''.

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

TITLE II—MEDICARE

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

SEC. 2000. SHORT TITLE; PURPOSE.

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

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

PART I—MEDICARE TOTAL HEALTH PROGRAM

SEC. 2001. ESTABLISHMENT OF MEDICARE TOTAL HEALTH PROGRAM.

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

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

(1) in the part heading, by striking ''**MEDICARE+CHOICE PROGRAM**'' and inserting ''**MEDICARE ADVANTAGE PROGRAM; MEDICARE TOTAL HEALTH PROGRAM**'';

(2) by inserting before section 1851 the following:

''Subpart 1—Medicare Advantage Program''; and

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

''Subpart 2—Medicare Total Health Program

''ELIGIBILITY, ENROLLMENT, AND INFORMATION

''SEC. 1860C–1. (a) ELIGIBILITY.—

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

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

''(B) through enrollment in a Total Health plan under this subpart.

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

''(3) TOTAL HEALTH ELIGIBLE INDIVIDUAL.—For purposes of this subpart, the term 'Total Health eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B who resides in a Total Health region.

''(4) TYPES OF TOTAL HEALTH PLANS THAT MAY BE AVAILABLE.—A Total Health plan may be any of the types of plans of health insurance described in section 1851(a)(2)(A), including a plan for special needs individuals described in clause (ii) of such section.

''(b) ENROLLMENT PROCESS FOR TOTAL HEALTH PLANS.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of Total Health eligible individuals in Total Health plans in a manner similar to (and

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

''(B) REQUIREMENTS.—Except as otherwise provided in this subsection, the process established under subparagraph (A) shall include a residency requirement similar to the residency requirement described in section 1851(b)(1) and shall take into account the process for exercising choice described in section 1851(c).

''(2) INITIAL ENROLLMENT PERIOD.—

''(A) PROGRAM INITIATION.—In the case of an individual who is a Total Health eligible individual as of November 15, 2016, there shall be an initial enrollment period beginning on October 15, 2016, and ending on December 7, 2016.

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

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

"(A) IN GENERAL.—As part of the process established under paragraph (1), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to 2017 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

"(4) SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods that are similar to the special enrollment periods established under section 1851(e)(4).

"(5) SPECIAL RULE.—

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

vidual (as defined in section 1935(c)(6))), for the enrollment in a Total Health plan with a monthly beneficiary premium under section 1860C–7(a) (taking into account any adjustment under subparagraph (B) or (C) of section 1860C–7(a)(2) and without regard to any adjustment under subparagraph (D) or (E) of such section) that does not exceed the base beneficiary premium computed under section 1860C–7(a)(1).

''(B) SELECTION OF PLAN BY THE SECRETARY.—In selecting a plan for the enrollment of a Total Health eligible individual under subparagraph (A), the Secretary shall first attempt to identify the Total Health plan in which the cost-sharing and health benefits are most similar to the coverage the individual had in the preceding plan year. If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the Total Health region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

"(C) INDIVIDUALS WHO ARE NOT TOTAL HEALTH ELIGIBLE INDIVIDUALS.—The Secretary shall establish procedures under which individuals who are entitled to, or enrolled for, coverage under part A or enrolled for coverage under part B (but not both), may continue to receive benefits with deductible and coinsurance amounts comparable to the benefits, deductible, and coinsurance amounts they would have received if this subpart had not been enacted.

"(c) PROVIDING INFORMATION TO BENEFICIARIES.—

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

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

information described in paragraph (3) of such section.

''TOTAL HEALTH PLAN BENEFITS

''SEC. 1860C–2. (a) REQUIREMENTS.—

''(1) QUALIFIED TOTAL HEALTH BENEFITS.—Each Total Health plan shall provide to individuals enrolled under this subpart, through providers and other persons that meet the applicable requirements of this title and part A of title XI, a qualified Total Health benefits package and qualified prescription drug coverage (described in section 1860D–2(a)).

''(2) DEFINITION OF QUALIFIED TOTAL HEALTH BENEFITS PACKAGE.—For purposes of this subpart, the term 'qualified Total Health benefits package' means either of the following:

''(A) STANDARD HEALTH BENEFITS COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard health benefits coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

''(B) ALTERNATIVE TOTAL HEALTH BENEFITS COVERAGE WITH AT LEAST ACTUARIALLY EQUIVALENT BENEFITS AND ACCESS TO NEGOTIATED PRICES.—Coverage of health benefits which meets the alternative health benefits coverage 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 subparagraph (B), a qualified Total Health benefits package may include supplemental health benefits 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 reduction 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 affecting the application of subsection (c)(3).

"(ii) ADDITIONAL BENEFITS.—Coverage of any health care item or service that is not covered under the original medicare fee-for-service program option or that is eligible for coverage under part D, subject to the approval of the Secretary.

"(B) REQUIREMENT FOR AT LEAST ONE BASIC BENEFITS PLAN.—A Total Health sponsor may not offer a Total Health plan that provides supplemental health benefits coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a Total Health plan in the area that only provides a basic Total Health benefits package.

"(4) BASIC TOTAL HEALTH BENEFITS PACKAGE.—For purposes of this subpart, the term 'basic Total Health benefits package' means either of the following:

"(A) Coverage that meets the requirements of paragraph (2)(A).

"(B) Coverage that meets the requirements of paragraph (2)(B) but does not have any supplemental health benefits coverage described in paragraph (3)(A).

''(5) APPLICATION OF SECONDARY PAYER PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this subpart in the same manner as such provisions applied to a Medicare Advantage plan.

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(3).

''(b) STANDARD HEALTH BENEFITS COVERAGE.—For purposes of this subpart, the term 'standard health benefits coverage' means coverage of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)), including the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible that is equal to the amount of the unified deductible for the year under section 1899C.

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

''(A) equal to 20 percent; or

''(B) actuarially equivalent (using processes and methods established by the Secretary)

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

''(3) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

''(A) IN GENERAL.—The coverage provides benefits, after the Total Health eligible individual has incurred costs (as described in subparagraph (C)) for health benefits in a year equal to—

''(i) the first threshold annual out-of-pocket limit specified in subparagraph (B)(i) for that year but less than the second threshold annual out-of-pocket limit specified in subparagraph (B)(ii) for that year, with coinsurance that is equal to 5 percent; and

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

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

''(i) FIRST THRESHOLD ANNUAL OUT-OF-POCKET LIMIT SPECIFIED.—The 'first threshold annual out-of-pocket limit' specified in this clause is equal to the first

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

"(ii) SECOND THRESHOLD ANNUAL OUT-OF-POCKET LIMIT SPECIFIED.—The 'second threshold annual out-of-pocket limit' specified in this clause is equal to the second threshold annual out-of-pocket limit for the year specified in section 1899B(b)(2).

"(C) APPLICATION.—In applying subparagraph (A), incurred costs shall only include costs incurred with respect to health benefits for the annual deductible described in paragraph (1) and for cost-sharing described in paragraph (2) or paragraph (3)(A)(i), or for benefits that would have otherwise been covered under the plan but for the exhaustion of those benefits. Incurred costs do not include any costs incurred for health benefits which are not included (or treated as being included) under the plan.

"(c) ALTERNATIVE TOTAL HEALTH BENEFITS COVERAGE REQUIREMENTS.—A Total Health plan may provide a different benefit design from standard health benefits coverage so long as the Secretary determines that the

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

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard health benefits coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage exceeds the subsidy payments with respect to such coverage.

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

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

"(i) the amount by which the costs incurred exceed the deductible described in subsection (b)(1) for the year; and

"(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2).

"(2) APPROVAL OF BENEFIT PACKAGE.—The benefit package is approved by the Secretary as containing a comparable range of benefits to standard health benefits coverage and meets such other requirements of this subpart as the Secretary may specify.

"(3) MAXIMUM REQUIRED DEDUCTIBLE.—The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

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

"(d) ACCESS TO NEGOTIATED PRICES.—

"(1) ACCESS.—

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

Total Health sponsor offering a Total Health plan, the sponsor shall provide enrollees with access to negotiated prices used for payment for covered health benefits, regardless of the fact that no benefits may be payable under the coverage with respect to such benefits because of the application of a deductible or other cost-sharing.

''(B) NEGOTIATED PRICES.—For purposes of this subpart, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered health benefits.

''(2) AUDITS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1857(d)(2)(B), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of Total Health sponsors with respect to Total Health Plans.

''(3) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—

''(A) IN GENERAL.—A Total Health plan may exclude from a qualified Total Health benefits package any health care item or service—

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

''(ii) which is not prescribed in accordance with the Total Health plan or this subpart.

''(B) RECONSIDERATION AND APPEAL.—Any exclusion under subparagraph (A) is a determination subject to reconsideration and appeal under this subpart.

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

''ACCESS TO A CHOICE OF QUALIFIED TOTAL HEALTH BENEFITS PLANS

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

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

least 2 Total Health plans in the area in which the individual resides.

''(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all of the qualifying plans in the area.

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

''BENEFICIARY PROTECTIONS FOR TOTAL HEALTH PLAN ENROLLEES

''SEC. 1860C–4. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A Total Health sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a Total Health plan offered by the sponsor under this subpart at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan, insofar as the Secretary determines appropriate with respect to benefits provided under this subpart, and including the information described in section 1860D–4 relating to qualified prescription drug coverage under the plan.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of a Total Health eligible individual who is eligible to enroll in a Total Health plan, the Total Health sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in section 1852(c)(2) to such individual.

''(3) PROVISION OF SPECIFIC INFORMATION.—Each Total Health sponsor offering a Total Health plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

''(4) CLAIMS INFORMATION.—

''(A) IN GENERAL.—A Total Health sponsor offering a Total Health plan must furnish to each enrollee in a form easily understandable to such enrollees—

''(i) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

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

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

''(II) the annual out-of-pocket limits under paragraph (3) of such section for the current year.

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

''(b) ACCESS TO HEALTH CARE PROVIDERS.—

''(1) ASSURING PROVIDER ACCESS.—

''(A) DISCOUNTS ALLOWED FOR NETWORK PROVIDERS.—For health benefits furnished through in-network providers, a Total Health plan may reduce coinsurance or copayments for Total Health eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1860C–8 to the Total Health sponsor of the plan.

''(B) CONVENIENT ACCESS FOR NETWORK PROVIDERS.—

''(i) IN GENERAL.—The Total Health sponsor of the Total Health plan shall secure the participation in its network of a sufficient number of health care providers that furnish health care items and services under the plan directly to patients to ensure convenient access (consistent with rules established by the Secretary).

''(ii) ADEQUATE EMERGENCY ACCESS.—Such rules shall include adequate emergency access for enrollees.

''(C) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits through any health care provider participating in the program under this title with any differential in charge paid by such enrollees.

''(2) USE OF STANDARDIZED TECHNOLOGY.—

''(A) IN GENERAL.—The Total Health sponsor of a Total Health plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to health benefits under this subpart.

''(B) STANDARDS.—

''(i) IN GENERAL.—The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of title XI and may be based on standards developed by an appropriate standard setting organization.

''(ii) CONSULTATION.—In developing the standards under clause (i), the Secretary shall consult with standard setting organizations determined appropriate by the Secretary.

''(iii) IMPLEMENTATION.—The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that Total Health sponsors utilize such standards beginning January 1, 2017.

''(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; WELLNESS PROGRAM.—

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

''(A) A cost-effective health benefits management program, including incentives to reduce costs when medically appropriate.

''(B) Quality assurance measures and systems to reduce errors and improve the use of health benefits.

''(C) A wellness program described in paragraph (2).

''(D) A program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a Total Health sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

''(2) WELLNESS PROGRAM.—

''(A) DESCRIPTION.—A wellness program described in this paragraph is a program focused on health improvement, disease prevention, and management of chronic conditions for Total Health eligible individuals enrolled in a plan under this part to optimize health outcomes through improved use of health care

items and services and to reduce the risk of adverse events.

''(B) ELEMENTS.—Such program may include elements that promote—

''(i) enhanced enrollee understanding to promote the appropriate use of health care items and services by enrollees and to reduce the risk of potential adverse events and to improve health outcomes through beneficiary education, counseling, and other appropriate means;

''(ii) increased enrollee adherence with recommended regimens through compliance programs and other appropriate means; and

''(iii) detection of adverse events and patterns of overuse and underuse of health care items and services.

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

"(D) WELLNESS PROGRAM ENROLLMENT.—The Total Health sponsor shall have in place a process to—

"(i) subject to clause (ii), automatically enroll plan enrollees in the wellness program required under this subsection; and

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

"(E) DEVELOPMENT OF PROGRAM IN COOPERATION WITH PHYSICIANS.—Such program shall be developed in cooperation with physicians.

"(F) COORDINATION WITH CARE MANAGEMENT PLANS.—The Secretary shall establish guidelines for the coordination of any wellness program under this paragraph with respect to a targeted beneficiary described in section 1860D–4(c)(2)(A)(i) (applied by substituting 'Total Health eligible individual' for 'part D eligible individual') with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1807.

''(G) CONSIDERATIONS IN PROVIDER FEES.—The Total Health sponsor of a Total Health plan shall take into account, in establishing fees for entities providing services under such plan, the resources used, and time required to, implement the wellness program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such fees.

''(d) CONSUMER SATISFACTION SURVEYS.—In order to provide for comparative information under section 1860C–1(c), the Secretary shall conduct consumer satisfaction surveys with respect to Total Health sponsors and Total Health plans in a manner similar to the manner such surveys were conducted for MA organizations and MA plans under subpart 1.

''(e) GRIEVANCE MECHANISM.—Each Total Health sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor provides covered benefits) and enrollees with Total Health plans of the sponsor under this part in accordance with section 1852(f).

''(f) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—A Total Health sponsor shall meet the re-

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

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

''(h) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—The provisions of section 1852(h) shall apply to a Total Health sponsor and Total Health plan in the same manner as such provisions applied to an MA organization and an MA plan.

''(i) TREATMENT OF ACCREDITATION.—Subparagraph (A) of section 1852(e)(4) (relating to treatment of accreditation) shall apply to a Total Health sponsor under this part in the same manner as such subparagraph applied to an MA organization.

''(j) REQUIREMENTS WITH RESPECT TO SALES AND MARKETING ACTIVITIES.—The following provisions shall apply to a Total Health sponsor (and the agents, brokers, and other third parties representing such sponsor) in the same manner as such provisions applied to a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization):

''(1) The prohibition under section 1851(h)(4)(C) on conducting activities described in section 1851(j)(1).

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

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

''(4) The requirements regarding the appointment of agents and brokers and compliance with State information requests under subparagraphs (A) and (B), respectively, of section 1851(h)(7).

''TOTAL HEALTH REGIONS; SUBMISSION OF BIDS; TOTAL HEALTH PLAN APPROVAL

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

''(1) COVERAGE OF ENTIRE TOTAL HEALTH REGION.—

"(A) IN GENERAL.—The service area for a Total Health plan shall consist of an entire Total Health region established under paragraph (2).

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

"(2) ESTABLISHMENT OF TOTAL HEALTH REGIONS.—

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

"(B) REGIONS TO BE LARGER THAN A SINGLE COUNTY.—Total Health regions shall include more than one county.

"(C) REGIONS WITHIN MSAS.—Among counties in a metropolitan statistical area, a Total Health region shall include all of the counties located in the same State in that metropolitan statistical area.

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

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

''(E) AUTHORITY FOR TERRITORIES.—The Secretary shall establish, and may revise, Total Health regions for areas in States that are not within the 50 States or the District of Columbia.

''(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing a Total Health plan from being offered in more than one Total Health region (including all Total Health regions).

''(b) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

''(1) IN GENERAL.—A Total Health sponsor shall submit to the Secretary information described in paragraph (2) with respect to each Total Health plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1854(a) was submitted by an MA organization under paragraph (1) of such section.

''(2) INFORMATION DESCRIBED.—The information described in this paragraph is information on the following:

''(A) BENEFITS PACKAGE PROVIDED.—The qualified Total Health benefits package provided under the plan, including the deductible and other cost-sharing.

''(B) ACTUARIAL VALUE.—The actuarial value of the qualified Total Health benefits package in the Total Health region for a Total Health eligible individual with a national average risk profile for the factors described in section 1860C–8(b)(1)(A) (as specified by the Secretary).

''(C) BID.—Information on the bid, including an actuarial certification of—

''(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

''(ii) the portion of such bid attributable to a basic Total Health benefits package and, if applicable, the portion of such bid attributable to supplemental benefits; and

''(iii) administrative expenses assumed in the bid.

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

''(E) LEVEL OF RISK ASSUMED.—Whether the Total Health sponsor requires a modification of risk level and, if so, the extent of such modification. Any such modification shall apply with respect to all Total Health plans offered by a Total Health sponsor in a Total Health region.

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

''(3) PAPERWORK REDUCTION FOR OFFERING OF TOTAL HEALTH PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for the submission of information under this subsection in a manner that promotes the offering of such plans in more than one Total Health region (including all regions) through the filing of consolidated information.

''(c) MEDICARE FEE-FOR-SERVICE BID.—For purposes of this subpart, the bid for benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)) is the dollar amount of the actuarial valuation of the benefits under that option for each Total Health region (as determined and submitted by the Chief Actuary of the Centers for Medicare & Medicaid

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

''(d) ACTUARIAL VALUATION.—

''(1) PROCESSES.—For purposes of this subpart, the Secretary shall establish processes and methods for determining the actuarial valuation of a Total Health benefits package, including—

''(A) an actuarial valuation of the benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)) in each service area;

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

''(C) the use of generally accepted actuarial principles and methodologies; and

''(D) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

''(2) ACCOUNTING FOR UTILIZATION.—Such processes and methods for determining actuarial valuation shall take into account the effect that providing a qualified Total Health benefits package (rather than benefits under the original medicare

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

"(3) RESPONSIBILITIES.—

"(A) PLAN RESPONSIBILITIES.—Total Health sponsors are responsible for the preparation and submission of actuarial valuations required under this subpart for the Total Health plans offered by the sponsor.

"(B) USE OF OUTSIDE ACTUARIES.—Under the processes and methods established under paragraph (1), Total Health sponsors offering a Total Health benefits package may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

"(e) REVIEW OF INFORMATION AND NEGOTIATION.—

"(1) REVIEW OF INFORMATION.—The Secretary shall review the information submitted under subsection (b) for the purpose of conducting negotiations under paragraph (2).

"(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

''(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

''(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

''(3) REJECTION OF BIDS.—Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a Total Health sponsor under subsection (b) in the same manner as such paragraph applied to bids submitted by an MA organization under such section 1854(a).

''(f) APPROVAL OF PROPOSED PLANS.—

''(1) IN GENERAL.—After review and negotiation under subsection (e), the Secretary shall approve or disapprove the Total Health plan.

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

''(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the Total Health sponsor 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).

''(B) MAXIMIZING ASSUMPTION OF RISK.—The Secretary shall provide priority in approval for those plans bearing the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

''(C) NO FULL UNDERWRITING FOR LIMITED RISK PLANS.—In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

''(3) ACCEPTANCE OF ALL FULL RISK CONTRACTS.—There shall be no limit on the number of full risk plans that are approved under subsection (e).

''(4) RISK-PLANS DEFINED.—For purposes of this subsection:

''(A) LIMITED RISK PLAN.—The term 'limited risk plan' means a Total Health plan that provides a basic Total Health benefits package and for which the Total Health sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in the bid submitted for the plan under such subsection.

''(B) FULL RISK PLAN.—The term 'full risk plan' means a Total Health plan that is not a limited risk plan.

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

''(i) NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

''(1) may not interfere with the negotiations between physicians or other health professionals, providers, suppliers, drug manufacturers, pharmacies, and Total Health sponsors; and

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

''REQUIREMENTS FOR AND CONTRACTS WITH TOTAL HEALTH SPONSORS

''SEC. 1860C–6. (a) GENERAL REQUIREMENTS.—Each sponsor of a Total Health plan shall meet the following requirements:

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

''(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a Total Health plan.

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

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a Total Health sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall not permit the enrollment under section 1860C–1 in a Total Health plan offered by a Total Health sponsor under this subpart, and the sponsor shall not be eligible for payments under section 1860C–8, unless the Secretary has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one Total Health plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this subpart and the terms and conditions of payment as provided for in this subpart.

''(2) INCORPORATION OF CERTAIN MEDICARE ADVANTAGE CONTRACT REQUIREMENTS.—Except as otherwise provided, the following provisions of section 1857 shall apply to contracts under this section in the same manner as such provisions applied to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b), except that—

''(i) the Secretary may increase the minimum number of enrollees required

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

"(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

"(B) CONTRACT PERIOD AND EFFECTIVENESS.—Section 1857(c), except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1853 is deemed a reference to payment amounts under section 1860C–8.

"(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

"(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that section 1857(e)(2) shall apply as specified to Total Health sponsors and payments to a Total Health plan under this subpart shall be treated as expenditures made under this subpart. Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1857(e)(1) to contracts under this section under the preceding sentence—

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

"(ii) shall be made available to Congressional support agencies (in accordance with their obligations to support Congress as set out in their authorizing statutes) for the purposes of conducting Congressional oversight, monitoring, making recommendations, and analysis of the program under this title.

"(E) INTERMEDIATE SANCTIONS.—Section 1857(g) (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this subpart.

"(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

"(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

"(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

''(ii) the application by a State of any grounds other than those required under Federal law.

''(B) SPECIAL RULES.—In applying subparagraph (A)(i)—

''(i) the ground of approval described in section 1855(a)(2)(B) is deemed to have been met if the State does not have a licensing process in effect with respect to the Total Health sponsor; and

''(ii) for plan years beginning before January 1, 2019, if the State does have such a licensing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

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

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

''(4) REFERENCES TO CERTAIN PROVISIONS.—In applying provisions of section 1855(a)(2) under paragraphs (2) and (3) of this subsection to Total Health plans and Total Health sponsors—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1)(A) of this subsection; and

''(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

''(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

''(1) ESTABLISHMENT AND PUBLICATION.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2016, financial solvency and capital adequacy standards for entities described in paragraph (2).

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

has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish certification procedures for such sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that a Total Health sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this subpart for a sponsor.

''(f) PERIODIC REVIEW AND REVISION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may periodically review the standards established under this section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

''(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations 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

increased by the portion of the Total Health approved bid that is attributable to supplemental benefits.

"(D) INCREASE FOR LATE ENROLLMENT PENALTY.—The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (e).

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

"(F) UNIFORM PREMIUM.—Except as provided in subparagraphs (D) and (E), the monthly beneficiary premium for a Total Health plan in a Total Health region is the same for all Total Health eligible individuals enrolled in the plan.

"(b) WEIGHTING OF BID AMOUNTS BASED ON ENROLLMENT.—

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

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

''(c) STANDARDIZED BID AMOUNT DEFINED.—For purposes of this subsection, the term 'standardized bid amount' means the following:

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

''(2) PLANS OFFERING SUPPLEMENTAL COVERAGE.—In the case of a Total Health plan that provides supplemental health benefits coverage, only the portion of the Total Health approved bid that is attributable to basic health benefits coverage.

''(d) TOTAL HEALTH APPROVED BID DEFINED.—For purposes of this subpart, the term 'Total Health approved bid' means—

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

''(2) with respect to the original medicare fee-for-service program option, the bid described in section 1860C–5(c).

''(e) LATE ENROLLMENT PENALTY.—The monthly beneficiary premium established under subsection (a) shall be subject to adjustment in the same manner as the part B monthly beneficiary premium computed under section 1839 is subject to adjustment under subsection (b) of such section, except that, in applying the late enrollment penalty under such subsection, the initial enrollment period of the individual shall be the enrollment period under 1860C–1(b)(2) instead of the initial enrollment period described in such section 1839(b).

''(f) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

''(1) IN GENERAL.—In the case of an individual whose modified adjusted gross income (as defined in paragraph (2)) exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section), the Secretary shall substitute the applicable percentage determined under paragraph (3)(C) of section 1839(i) for the individual for the calendar year for the percentage described in subsection (a)(1)(A).

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

termined for the taxable year applicable under subparagraphs (B) and (C) of such section.

''(3) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this subsection.

''(4) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

''(A) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2016, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under subsection (a)(1)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this subsection with respect to the following year.

''(B) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2016, the Secretary shall disclose to the Commissioner of Social Security the following information 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

''(2) the base beneficiary premium (as computed under paragraph (1) of section 1860C–7(a) and as adjusted under paragraph (2)(B) of such section).

''(b) ADJUSTMENTS RELATING TO BIDS.—

''(1) HEALTH STATUS RISK ADJUSTMENT.—

''(A) ESTABLISHMENT OF RISK ADJUSTORS.—The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1) to take into account variation in costs for health benefits coverage among Total Health plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a) and through that portion of the monthly beneficiary Total Health premiums described in subsection (a)(2).

''(B) CONSIDERATIONS.—In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1853(a)(3) to 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-

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

''(C) BUDGET NEUTRAL ADJUSTMENT.—Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this subpart that would have been made if the Secretary had not applied such adjustment.

''(c) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

''(2) REQUIREMENT FOR PROVISION OF INFORMATION.—

''(A) REQUIREMENT.—Payments under this section to a Total Health sponsor are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

"(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

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

"(4) APPLICATION OF ENROLLEE ADJUSTMENT.—The provisions of section 1853(a)(2) shall apply to payments to Total Health sponsors under this section in the same manner as they applied to payments to MA organizations under section 1853(a).

"(d) PLANS AT RISK FOR ENTIRE AMOUNT OF BENEFITS.—A Total Health sponsor that offers a plan under this subpart shall be at full financial risk for the provision of benefits under such plan.

"(e) DISCLOSURE OF INFORMATION.—

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

''(A) the Total Health sponsor offering a Total Health plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

''(B) the Secretary shall have the right in accordance with section 1857(d)(2)(B) (as applied under section 1860C–6(b)(2)(C)) to inspect and audit any books and records of a Total Health sponsor that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

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

''(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

''(i) carrying out this section; and

''(ii) conducting oversight, evaluation, and enforcement under this title; and

''(B) by the Attorney General and the Comptroller General of the United States for

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

''EXEMPTION FOR MSA PLANS

''SEC. 1860C–9. (a) IN GENERAL.—None of the provisions in this subpart shall apply to an MSA plan (as defined in section 1859(b)(3)) and an MSA plan may not be a Total Health plan.

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

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

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

''SPECIAL RULES FOR EMPLOYER-SPONSORED PROGRAMS

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

''(1) IN GENERAL.—The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree health benefits plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Sec-

retary to provide for the payment of amounts provided under this section.

''(2) QUALIFIED RETIREE HEALTH BENEFITS PLAN DEFINED.—For purposes of this subsection, the term 'qualified retiree health benefits plan' means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a Total Health eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

''(A) ATTESTATION OF ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of health benefits coverage under the plan (as determined using the processes and methods described in section 1860C–5(d)) is at least equal to the actuarial value of standard health benefits coverage.

''(B) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary 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,

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

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) ALLOWABLE RETIREE COSTS.—The term 'allowable retiree costs' means, with respect to gross covered health benefits costs under a qualified retiree health benefits plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

''(ii) GROSS COVERED RETIREE PLAN-RELATED HEALTH BENEFITS COSTS.—The term 'gross covered retiree plan-related health benefits costs' means, with respect to a qualifying covered retiree enrolled in a qualified retiree health benefits plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the furnishing of health benefits items and services during the year. Such

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

''(iii) COVERAGE YEAR.—The term 'coverage year' has the meaning given such term in section 1860D–15(b)(4) (as applied by substituting 'covered health benefits' for 'covered part D drugs').

''(4) QUALIFYING COVERED RETIREE DEFINED.—For purposes of this subsection, the term 'qualifying covered retiree' means a Total Health eligible individual who is not enrolled in a Total Health plan but is covered under a qualified retiree health benefits plan.

''(5) PAYMENT METHODS, INCLUDING PROVISION OF NECESSARY INFORMATION.—The provisions of section 1860C–8(c) (including paragraph (2) of such section, relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payments under section 1860C–8.

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) precluding a Total Health eligible individual who is covered under employment-

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

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

"(C) preventing such employment-based retiree health coverage from providing coverage—

"(i) that is better than standard health benefits coverage to retirees who are covered under a qualified retiree health benefits plan; or

"(ii) that is supplemental to the benefits provided under a Total Health plan, including benefits to retirees who are not covered under a qualified retiree health benefits plan but who are enrolled in such a Total Health plan; or

"(D) preventing employers from providing for flexibility in benefit design and provider access provisions, without regard to the requirements for basic health benefits coverage, so

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

''(b) APPLICATION OF MEDICARE ADVANTAGE WAIVER AUTHORITY.—The provisions of section 1857(i) shall apply with respect to Total Health plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they applied to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a Total Health plan by reason of such coverage and limitations on enrollment to Total Health eligible individuals enrolled under such coverage.

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

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for Total Health eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

''(2) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section (16)(B) of the

Employee Retirement Income Security Act of 1974, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

''(3) GROUP HEALTH PLAN.—The term 'group health plan' includes such a plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 and also includes the following:

''(A) FEDERAL AND STATE GOVERNMENTAL PLANS.—Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5, United States Code.

''(B) COLLECTIVELY BARGAINED PLANS.—Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

''(C) CHURCH PLANS.—Such a plan established and maintained for its employees (or

their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

''COORDINATION WITH STATE MEDICAID PROGRAMS

''SEC. 1860C–11. (a) APPLICATION.—

''(1) IN GENERAL.—Subject to subsection (c)(2), a State may apply to the Secretary for the waiver of any or all requirements described in this subpart for plan years beginning on or after January 1, 2017, with respect to a Total Health plan offered within the State for the purpose of coordinating that plan with its State plan under title XIX to ensure—

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

''(B) the development of innovative care coordination and integration models; and

''(C) the elimination of financial misalignments that lead to poor quality and cost-shifting.

''(2) REQUIREMENTS.—Such application shall—

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

"(B) contain such information as the Secretary may require, including—

"(i) a comprehensive description of the proposal and program to implement a plan meeting the requirements for a waiver under this section; and

"(ii) an analysis of the proposal demonstrating that the plan will not increase Federal Government expenditures; and

"(C) provide an assurance that, if approved, the Total Health sponsor will offer the plan that is the subject of the proposal.

"(3) WAIVER CONSIDERATION AND TRANSPARENCY.—

"(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

"(B) REGULATIONS.—Not later than 180 days after the date of enactment of this subpart, the Secretary shall promulgate regulations relating to waivers under this section that provide—

''(i) a process for public notice and comment sufficient to ensure a meaningful level of public input;

''(ii) a process for the submission of an application for the waiver;

''(iii) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

''(iv) a process for the periodic evaluation by the Secretary of the program under the waiver.

''(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

''(4) STATE OPTION TO BE A TOTAL HEALTH SPONSOR.—For purposes of this section, a State may elect to be the sponsor of a Total Health plan for residents of the State who are eligible for benefits under this title and title XIX or to apply on behalf of a Total Health sponsor offering a Total Health plan in the State.

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

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

''(b) GRANTING OF WAIVERS.—

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

''(A) will provide coverage that is at least as comprehensive as the coverage described in section 1860C–2(a)(1) as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services;

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

''(C) will not increase the Federal deficit.

''(c) SCOPE OF WAIVER.—

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

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

''(d) DETERMINATIONS BY THE SECRETARY.—

''(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

''(2) EFFECT OF DETERMINATION.—

''(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the Total Health sponsor involved of such determination and the terms and effectiveness of such waiver.

''(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the Total Health sponsor involved, including the reasons therefor.

''(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the Total Health sponsor requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of the

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

''DEFINITIONS AND MISCELLANEOUS PROVISIONS

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

''(1) BASIC HEALTH BENEFITS COVERAGE.—The term 'basic health benefits coverage' means coverage of the health care items and services for which payment may be made under the original medicare fee-for-service program option.

''(2) INSURANCE RISK.—The term 'insurance risk' means, with respect to a participating health care provider, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the health care provider.

''(3) MA PLAN; MEDICARE ADVANTAGE PLAN.—The terms 'MA plan' and 'Medicare Advantage plan' have the meaning given such terms in section 1859(b)(1).

''(4) ORIGINAL MEDICARE FEE-FOR-SERVICE 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.

''(b) APPLICATION OF SUBPART 1 PROVISIONS AND REGULATIONS UNDER THIS SUBPART.—For purposes of applying provisions of subpart 1 under this subpart (and regulations implementing such provisions) with respect to a Total Health plan and a Total Health sponsor, unless otherwise provided in this subpart, and to the extent consistent with this subpart, such provisions (and regulations implementing such provisions) shall be applied as the provisions (and regulations) applied for plan years beginning prior to January 1, 2017, and as if—

''(1) any reference to a Medicare Advantage plan or an MA plan included a reference to a Total Health plan;

''(2) any reference to an MA organization or a provider-sponsored organization included a reference to a Total Health sponsor;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860C–6(b);

''(4) any reference to subpart 1 included a reference to this subpart; and

''(5) any reference to an election period under section 1851 were a reference to an enrollment period under section 1860C–1.''.

SEC. 2002. REPLACEMENT OF PART B PREMIUM WITH MEDICARE TOTAL HEALTH PROGRAM PLAN PREMIUM; OTHER TECHNICAL AND CONFORMING AMENDMENTS.

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

(1) in subsection (a)(2), by striking ''The monthly premium'' and inserting ''Subject to subsection (j),''; and

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

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

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), on and after January 1, 2017, in lieu of the premium otherwise applicable under this section, the monthly premium of each Total Health eligible individual (as defined in section 1860C–1(a)(3)) shall be the monthly beneficiary premium determined under section 1860C–7 for the Total Health plan or the original medicare fee-for-service program option and the plan year involved.

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

"(3) CREDITING OF PREMIUMS.—Premiums paid by each Total Health eligible individual enrolled in the original medicare fee-for-service program option (as defined in section 1860E–13(a)(4)), shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund under section 1841.".

(b) OTHER TECHNICAL AND CONFORMING AMENDMENTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this part and part II.

PART II—MEDICARE FEE-FOR-SERVICE REFORMS

SEC. 2011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR FEE-FOR-SERVICE BENEFITS.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

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

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

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

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

''(b) AMOUNT OF ANNUAL OUT-OF-POCKET LIMITS.—

''(1) FIRST THRESHOLD ANNUAL OUT-OF-POCKET LIMIT.—The amount of the first threshold annual out-of-pocket limit under this subsection shall be—

''(A) for 2015, $5,500; or

''(B) for a subsequent year, the amount 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).

''(2) SECOND THRESHOLD ANNUAL OUT-OF-POCKET LIMIT.—The amount of the second threshold annual out-of-pocket limit under this subsection shall be—

''(A) for 2015, $7,500; or

''(B) for a subsequent year, the amount 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-

ices which are not included (or treated as being included) under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

''(B) ITEMS AND SERVICES NOT FURNISHED ON AN ASSIGNMENT-RELATED BASIS.—If an item or service is furnished to an individual under this title and is not furnished on an assignment-related basis, any additional expenses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

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

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

provide notice to all interested parties) the annual out-of-pocket limit under this section and the unified deductible under section 1899C that will be applicable for the succeeding year.''.

SEC. 2012. UNIFIED MEDICARE DEDUCTIBLE.

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

''UNIFIED PART A AND B DEDUCTIBLE

''SEC. 1899C. (a) IN GENERAL.—Notwithstanding any other provision of this title, subject to subsection (d), for a year (beginning with 2015), in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B—

''(1) the amount otherwise payable under part A and the total amount of expenses incurred by the individual during a year which would (except for this section) constitute incurred expenses for which benefits payable under section 1833(a) are determinable, shall be reduced by the amount of the unified deductible under subsection (b); and

''(2) the individual shall be responsible for payment of such amount.

''(b) AMOUNT OF UNIFIED DEDUCTIBLE.—

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

''(A) for 2015, $550; or

''(B) for a subsequent year, the amount 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).

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

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

''(1) With respect to items and services covered under part A, such unified deductible shall be applied on the basis of the amount that is payable for such items and services without regard to any copayments or coinsurance and before the application of any such copayments or coinsurance.

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

plied on the basis of the total amount of the expenses incurred by the individual during a year which would, except for the application of the unified deductible, constitute incurred expenses for which items and services are payable under part B, without regard to any copayments or coinsurance and before the application of any such copayments or coinsurance.

''(3)(A) Except as provided in subparagraph (B), such unified deductible shall be applied with respect to all items and services covered under parts A and B and in lieu of the deductibles described in sections 1813(b) and 1833(b) or otherwise.

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

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

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

SEC. 2013. UNIFORM MEDICARE COINSURANCE RATE.

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

''UNIFORM PART A AND B COINSURANCE RATE

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

''(b) APPLICATION TO ALL ITEMS AND SERVICES.—The uniform coinsurance under this section for a year shall be applied as follows:

''(1) With respect to items and services covered under part A, such uniform coinsurance shall be applied on the basis of the amount that is payable for such items and services.

''(2) With respect to items and services covered under part B, such uniform coinsurance shall be applied on the basis of the total amount of the expenses incurred by the individual during a year which would, except for the application of the unified deductible, constitute incurred expenses from which items and services are payable under part B.

''(3)(A) Except as provided in subparagraph (B), such uniform coinsurance shall be applied with respect to all items and services covered under parts A and B and in lieu of any other copayments or coinsurance under such parts.

''(B) Coinsurance for blood under this title shall be determined under the rules that were applicable to blood on December 31, 2014, rather than under this section.''.

(b) CONFORMING AMENDMENTS.—

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

(A) in subsection (a), by inserting ''Subject to sections 1899B, 1899C, and 1899D:'' before paragraph (1); and

(B) in subsection (b), by inserting ''Subject to sections 1899B, 1899C, and 1899D:'' before paragraph (1).

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

(A) in subsection (a), in the matter preceding paragraph (1), by inserting ''and sections 1899B, 1899C, and 1899D'' after ''succeeding provisions of this section'';

(B) in subsection (b), in the first sentence, by striking ''Before applying'' and inserting ''Subject to sections 1899B, 1899C, and 1899D, before applying'';

(C) in subsection (c)(1), in the matter preceding subparagraph (A), by inserting ''subject to sections 1899B, 1899C, and 1899D,'' after ''this part,'';

(D) in subsection (f), by striking ''In establishing'' and inserting ''Subject to sections

1899B, 1899C, and 1899D, in establishing''; and

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

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

(A) in subparagraph (B), striking ''section 1813'' and inserting ''sections 1813 and 1899C''; and

(B) in subparagraph (C), by striking ''and section 1833(b)'' and inserting '', 1833(b), and 1899C''.

SEC. 2014. PROHIBITION ON FIRST-DOLLAR COVERAGE UNDER MEDIGAP POLICIES AND DEVELOPMENT OF NEW STANDARDS FOR MEDIGAP POLICIES.

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

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

''(1) DEVELOPMENT.—The Secretary shall request the National Association of Insurance Com-

missioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from the enactment of the The Dollar for Dollar Act of 2012 and to otherwise update standards to include the requirements for cost-sharing described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the The Dollar for Dollar Act of 2012. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

''(2) COST-SHARING REQUIREMENTS.—The cost-sharing requirements described in this paragraph are that, notwithstanding any other provision of law, no medicare supplemental policy may provide for coverage of—

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

"(B) more than 50 percent of the cost-sharing (excluding premiums) otherwise applicable under parts A and B after the individual has met the unified deductible under section 1899C(b) for the year and before the individual has reached the first threshold annual out-of-pocket limit under section 1899B(b)(1) for the year.

"(3) RENEWABILITY.—The renewability requirement under subsection (q)(1) shall be satisfied with the renewal of the revised package under paragraph (1) that most closely matches the policy in which the individual was enrolled prior to such revision.

"(aa) LIMITATION ON ISSUING NEW MEDICARE SUPPLEMENTAL POLICIES AFTER 2016.—

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

''(2) RENEWALS AND NEW POLICIES.—Nothing in this subsection shall be construed as prohibiting—

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

''(B) the issuance of a new medicare supplemental policy after such date as long as the individual was covered under any medicare supplemental policy as of such date.''.

PART III—ANNUAL REPORT TO CONGRESS

SEC. 2021. ANNUAL REPORT TO CONGRESS.

(a) IN GENERAL.—Not later than July 1, 2016, and annually thereafter, the Secretary of Health and Human Services shall submit to the Committee on Finance and the Special Committee on Aging of the Senate and to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the provisions of, and amendments made by, parts I and II.

(b) CONTENTS.—The report submitted under subsection (a) shall contain the following information:

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

(2) An evaluation of changes in access to physicians and other health care providers as a result of such provisions and amendments.

(3) An evaluation of changes in beneficiary satisfaction under the Medicare program as a result of such provisions and amendments.

(4) Such other information as the Secretary determines to be appropriate.

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.

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

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

(2) by striking subsection (c).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

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.

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

(1) in paragraph (2)(A), by inserting (or, in the case of 2013 or a subsequent year, $50,000) after ''$80,000''; and

(2) in paragraph (3)—

(A) in subparagraph (A)(i)—

(i) by inserting ''applicable'' before ''table''; and

(ii) by inserting ''and year'' after ''individual''; and

(B) in subparagraph (C)(i)—

(i) by striking ''(i) IN GENERAL.—'' and inserting ''(i)(I) FOR 2007 THROUGH 2012.—For each of 2007 through 2012:''; and

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

"(II) FOR 2013 AND SUBSEQUENT 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.".

(b) EXTENSION OF TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—

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

(A) in the matter preceding subparagraph (A), by striking "December 31, 2019" and inserting "December 31, 2021";

(B) in subparagraph (A), by striking "equal to such amount for 2010; and" and inserting the following: "equal to—

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

"(ii) in the case of each of 2013 through 2021, such amount for 2013; and"; and

(C) in subparagraph (B), by striking ''equal to such dollar amounts for 2010.'' and inserting the following: ''equal to—

''(i) in the case of each of 2011 and 2012, such dollar amounts for 2010; and

''(ii) in the case of each of 2013 through 2021, such dollar amounts for 2013.''.

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

Subtitle D—Increase in the Medicare Eligibility Age

SEC. 2301. INCREASE IN THE MEDICARE ELIGIBILITY AGE.

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

''(k) INCREASING MEDICARE QUALIFYING AGE.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, any reference in this section, title XVIII, or title XIX (insofar as it relates to the eligibility age for Medicare benefits under title XVIII) to 'age 65' shall be deemed a reference to the Medicare qualifying age specified in paragraph (2).

''(2) MEDICARE QUALIFYING AGE SPECIFIED.—The Medicare qualifying age specified in this paragraph is determined as follows:

''(A) In the case of an individual who attains 65 years of age before January 1, 2014, the Medicare qualifying age is 65 years of age.

''(B) In the case of an individual who attains 65 years of age in a year after 2013, and before 2025, the Medicare qualifying age is the Medicare qualifying age specified in this paragraph for the previous year increased by 2 months.

''(C) In the case of an individual who attains 65 years of age in a year after 2024, the Medicare qualifying age is 67 years of age.''.

Subtitle E—Other Provisions

SEC. 2401. LIMITATION ON MEDICARE PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION (DGME).

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

''(v) CAP ON APPROVED FTE RESIDENT AMOUNT.—

"(I) IN GENERAL.—The approved FTE resident amount for a hospital for a cost reporting period beginning during fiscal year 2013 or a subsequent fiscal year shall not be more than the applicable amount for the year.

"(II) APPLICABLE AMOUNT.—For purposes of subclause (I), the applicable amount for a year shall be an amount equal to 120 percent of the national average salary paid to residents in 2010, updated through the year involved by the Chained Consumer Price Index.

"(III) CHAINED CONSUMER PRICE INDEX.—In subclause (II), the term 'Chained Consumer Price Index' means the initial Chained Consumer Price Index for all-urban consumers published by the Department of Labor.".

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

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

(1) in subclause (XI), by striking ''and'' at the end;

(2) in subclause (XII)—

(A) by inserting ''and before October 1, 2012,'' after ''2007,''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(XIII) on or after October 1, 2012, 'c' is equal to 0.54.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting ''or of section 2402(a) of the The Dollar for Dollar Act of 2012'' after ''Act of 1997''.

SEC. 2403. ACCELERATION OF APPLICATION OF PRODUCTIVITY ADJUSTMENT TO MEDICARE HOME HEALTH PROSPECTIVE PAYMENT AMOUNTS.

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

SEC. 2404. ACCELERATION OF REBASING OF MEDICARE HOME HEALTH PROSPECTIVE PAYMENT AMOUNTS.

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

(1) in the first sentence—

(A) by striking ''4-year'' and inserting ''2-year''; and

(B) by striking ''2017'' and inserting ''2015''; and

(2) by striking the second sentence.

SEC. 2405. REDUCTION OF BAD DEBT TREATED AS AN ALLOWABLE COST.

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

(1) in clause (iv), by striking ''and'' at the end;

(2) in clause (v)—

(A) by striking ''or a subsequent fiscal year''; and

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

(3) by adding at the end the following:

''(vi) for cost reporting periods beginning during fiscal year 2014, by 48 percent of such amount otherwise allowable,

''(vii) for cost reporting periods beginning during fiscal year 2015, by 61 percent of such amount otherwise allowable,

''(viii) for cost reporting periods beginning during fiscal year 2016, by 74 percent of such amount otherwise allowable,

''(ix) for cost reporting periods beginning during fiscal year 2017, by 87 percent of such amount otherwise allowable, and

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

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

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

(2) in clause (i)—

(A) in subclause (I), by striking ''and'' at the end;

(B) in subclause (II)—

(i) by striking ''or a subsequent fiscal year''; and

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

(C) by adding at the end the following:

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

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

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

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

''(VII) for cost reporting periods beginning during fiscal year 2018 or a subsequent fiscal year, by 100 percent of such amount otherwise allowable.''.

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

(1) in subclause (II), by striking ''and'' at the end;

(2) in subclause (III)—

(A) by striking ''a subsequent fiscal year'' and inserting ''fiscal year 2015''; and

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

(3) by adding at the end the following:

''(IV) for cost reporting periods beginning during fiscal year 2016, by 48 percent of such amount otherwise allowable;

''(V) for cost reporting periods beginning during fiscal year 2017, by 61 percent of such amount otherwise allowable;

''(VI) for cost reporting periods beginning during fiscal year 2018, by 74 percent of such amount otherwise allowable;

''(VII) for cost reporting periods beginning during fiscal year 2019, by 87 percent of such amount otherwise allowable; and

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

by 100 percent of such amount otherwise allowable.''.

TITLE III—SOCIAL SECURITY

SEC. 3101. ADJUSTMENTS TO BEND POINTS IN DETERMINING PRIMARY INSURANCE AMOUNT.

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

(1) in subparagraph (A), in the matter preceding clause (i), by inserting ''who initially becomes eligible for old-age or disability insurance benefits, or who dies (before becoming eligible for such benefits), in any calendar year after 1979 and before 2017'' after ''individual'';

(2) in subparagraph (B)(ii), in the matter preceding subclause (I), by inserting ''and before 2017'' after ''after 1979'';

(3) in subparagraph (C)(i), by inserting ''or (E)'' after ''(A)''; and

(4) by adding at the end the following:

''(E)(i) The primary insurance amount of an individual who initially becomes eligible for old-age or disability insurance benefits, or who dies (before becoming eligible for such benefits), in any calendar year after 2016 shall (except as otherwise provided in this section) be equal to the sum of—

''(I) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this subclause by clause (ii),

''(II) 30 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of subclause (I) but do not exceed the amount established for purposes of this subclause by clause (ii),

''(III) 10 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of subclause (II) but do not exceed the amount established for purposes of this subclause by clause (ii), and

''(IV) 5 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of subclause (III),

rounded, if not a multiple of $0.10, to the next lower multiple of $0.10, and thereafter increased as provided in subsection (i).

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

becoming eligible for such benefits) in the calendar year 2017 or later, the amount established for purposes of subclauses (I), (II), and (III) of subparagraph (E)(i) shall be $180, $736, and $1,085, respectively, as if such amount was applicable with respect to 1979 and was adjusted for years after 1979 in the same manner as provided under subparagraph (B)(ii), without regard to the limitation that such adjustment only applies to individuals who initially become eligible for old-age benefits or disability insurance benefits, or who die (before becoming eligible for benefits) before 2017.

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

''(aa) the primary insurance amount determined for the individual under subparagraphs (A) and (B) (without regard to the limitation that such subparagraphs apply only to individuals who initially become eligible for old-age benefits or disability insurance benefits, or who die (before becoming eligible for benefits) before 2017) multiplied by the applicable

phase-in factor for the calendar year under subclause (II); and

''(bb) the primary insurance amount determined for the individual under this subparagraph (other than under this clause) multiplied by the applicable phase-in factor for the calendar year under subclause (II).

''(II) For purposes of—

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

''(AA) the numerator applicable for the preceding year reduced by 1, divided by

''(BB) 34; and

''(bb) subclause (I)(bb), the applicable phase-in factor for calendar year 2017 is the quotient of 1 divided by 34, and for each year thereafter is the quotient of—

''(AA) the numerator applicable for the preceding year increased by 1, divided by

''(BB) 34.''.

SEC. 3102. ADJUSTMENT TO CALCULATION OF BENEFIT COMPUTATION YEARS.

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

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

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

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

''(III) after December 31, 2014, and before January 1, 2016, by 3 years; and

''(IV) after December 31, 2015, and before January 1, 2017, by 2 years; and''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for months beginning after December 31, 2013.

SEC. 3103. MINIMUM SOCIAL SECURITY BENEFIT.

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

''Minimum Monthly Insurance Benefit

''(j)(1) Notwithstanding the preceding provisions of this section—

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

''(i) the primary insurance amount determined under this section (without regard to this subsection), or

''(ii) the minimum monthly insurance benefit determined under paragraph (2), and

''(B) any recomputation of the primary insurance amount of a qualified individual shall not result in a primary insurance amount less than the primary insurance amount as in effect immediately prior to such recomputation.

''(2) For purposes of this subsection, the term 'minimum monthly insurance benefit' means 1/12 of the applicable percentage of the adjusted minimum benefit level (as defined in paragraph (5)).

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

mined under subparagraph (B)(ii) for each year of coverage of the qualified individual less than 30.

''(B)(i) In the case of an individual who initially becomes eligible for disability insurance benefits under section 223 before attaining age 62, or who dies before attaining age 62, in a month beginning after December 31, 2016, and who is credited with at least 5 years of coverage, the individual shall be treated as a qualified individual and the applicable percentage shall be 125 reduced by the number of percentage points determined under clause (ii) for each year of coverage of the qualified individual less than the number as determined under clause (iii).

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

''(I) dividing the number of the qualifying individual's elapsed years (as defined in subsection (b)(2)(B)(iii)) by 40;

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

''(III) dividing 125 by the result under subclause (II) and rounding to the nearest one hundredth of 1 percentage point.

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

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

''(4) For purposes of this subsection, a year of coverage is a calendar year for which an individual is credited with 4 quarters of coverage.

''(5) For purposes of this subsection—

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

''(B) for individuals who initially become eligible for old-age or disability insurance benefits or die (before becoming eligible for such benefits) in a year after 2017, the term 'adjusted minimum benefit level' means the amount specified in subparagraph (A), multiplied by the quotient described in sub-

section (b)(3)(A)(ii), except that the reference to 'the computation base year for which the determination is made' in such subsection shall be deemed instead to be a reference to '2009'.

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

(b) CONFORMING AMENDMENT.—Section 202(a) of such Act (42 U.S.C. 402(a)) is amended in the last sentence by striking ''section 215(a)'' and inserting ''section 215''.

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

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

''Increased Monthly Insurance Benefit After 20 Years of Initial Eligibility

''(k)(1) Notwithstanding the preceding provisions of this section, in the case of an individual who is a 20-year beneficiary, the primary insurance amount of the individual (as determined before the application of this subsection) shall be increased for months beginning with the first month for which the individual attains such status

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

''(2) For purposes of this subsection, the term '20-year beneficiary' means an individual who has been eligible for old-age insurance benefits or disability insurance benefits under this title for at least 240 months.

''(3) For purposes of paragraph (1), the term 'applicable average primary insurance amount' means, with respect to a 20-year beneficiary, the primary insurance amount determined by the Commissioner of Social Security that would apply to an individual of the same age as the age at which the 20-year beneficiary first attains such status, if the individual had earnings for each calendar year in which the individual would have attained ages 20 through the year prior to the age of eligibility, respectively, equal to the national average earnings for all such individuals for each such year.

''(4) For purposes of paragraph (1), the applicable percentage is—

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

''(B) for each month occurring during the second 12-month period for which an individual is such a beneficiary, 2 percent;

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

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

''(E) for each month occurring thereafter, 5 percent.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for months beginning after December 31, 2013.

SEC. 3105. ADJUSTMENT TO NORMAL AND EARLY RETIREMENT AGES.

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

(1) in paragraph (1)—

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

(B) by striking subparagraph (E) and inserting the following new subparagraphs:

''(E) with respect to an individual who attains early retirement age after December 31, 2021, and before January 1, 2023, 67 years of 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 individual's early retirement age plus 60 months; or

"(ii) attains early retirement age pursuant 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 pursuant to paragraph (2)(B) after December 31, 2069, 69 years of age.";

(2) by amending paragraph (2) to read as follows:

"(2) The term 'early retirement age' means—

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

''(i) 62 years of age with respect to an individual who attains such age before January 1, 2023;

''(ii) with respect to an individual who attains 62 years of age after December 31, 2022, and before January 1, 2070, 62 years of age plus the number of months determined under the age increase factor for the calendar year in which such individual attains 62 years of age; and

''(iii) with respect to an individual who attains age 62 after December 31, 2069, 64 years of age; or

''(B) in the case of a widow's or widower's insurance benefit, 60 years of age.''; and

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

''(4) The age increase factor shall be equal to 1/24 of the number of months (rounded down to a full month) in the period beginning with January 2023 and ending with December of the year in which—

''(A) for purposes of paragraph (1)(F)(ii), the individual attains 60 years of age; or

''(B) for purposes of paragraph (2)(A)(ii), the individual attains 62 years of age.''.

SEC. 3106. APPLICATION OF ACTUARIAL REDUCTION FOR DISABLED BENEFICIARIES WHO ATTAIN EARLY RETIREMENT AGE.

(a) IN GENERAL.—Section 202(k)(4) of the Social Security Act (42 U.S.C. 402(k)(4)) is amended to read as follows:

''(4)(A) Subject to subparagraph (B), any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this title shall be entitled to only the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.

''(B) An individual described in subparagraph (A) who has attained transitional retirement age (as determined under subparagraph (C)) shall only be entitled to the old-age insurance benefit for such month, as reduced for such month pursuant to subsection (q)(1).

''(C) For purposes of subparagraph (B), the term 'transitional retirement age' means—

''(i) with respect to an individual who attains 62 years of age before January 1, 2014, 66 years of age;

''(ii) with respect to an individual who attains 62 years of age after December 31, 2013, and before January 1, 2025, 66 years of age reduced by the number of months determined under the transition factor (as determined under subparagraph (D)) for the calendar year in which such individual attains 62 years of age; and

''(iii) with respect to an individual who attains 62 years of age after December 31, 2024, 64 years of age.

''(D) For purposes of subparagraph (C)(ii), the transition factor shall be equal to two-twelfths of the number of months in the period beginning with January 2014 and ending with December of the year in which the individual attains 62 years of age.''.

(b) CONFORMING AMENDMENTS.—

(1) PERIOD OF DISABILITY.—Clause (i) of section 216(i)(2)(D) of the Social Security Act (42 U.S.C. 416(i)(2)(D)) is amended by striking ''retirement age (as defined in subsection (l))'' and inserting ''transitional retirement age (as defined in section 216(k)(4))''.

(2) DISABILITY INSURANCE BENEFIT PAYMENTS.—Section 223(a)(1) of the Social Security (42 U.S.C. 423(a)(1)) is amended—

(A) in subparagraph (B), by striking ''retirement age (as defined in section 216(l))'' and inserting ''transitional retirement age (as defined in section 216(k)(4))''; and

(B) in the flush matter at the end, by striking ''retirement age (as defined in section 216(l))'' and inserting ''transitional retirement age (as defined in section 216(k)(4))''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for months beginning after December 31, 2013.

SEC. 3107. OPTION TO COLLECT UP TO ONE-HALF OF OLD-AGE INSURANCE BENEFIT AT AGE 62.

(a) IN GENERAL.—Section 202 of the Social Security Act (42 U.S.C. 402) is amended by adding at the end the following:

''Option To Collect up to One-Half of Old-Age Insurance Benefit Beginning at Age 62

''(z)(1) Not later than January 1, 2014, the Commissioner of Social Security shall establish an option, subject to such regulations as are prescribed by the Commissioner under paragraph (2), for a fully insured individual (as defined in section 214) to elect to receive a reduced monthly benefit after such individual attains 62 years of age, consisting of the following:

''(A) Subject to paragraph (3), for months beginning with the month in which the individual attains age 62, a monthly benefit equal to such percentage as is elected by the individual, but which shall not be greater than 50 percent, of the primary insurance amount determined for the individual at age 62.

''(B) For months beginning with the month in which the individual attains early retirement age, a monthly benefit equal to the sum of—

''(i) the monthly benefit payable to the individual under subparagraph (A); and

''(ii) the amount equal to the applicable percentage (as determined under subparagraph (C)) of primary insurance amount determined for the individual under section 215 for such month (determined without regard to any election under this subsection).

''(C) For purposes of subparagraph (B)(ii), the applicable percentage shall be equal to the difference between—

''(i) 100 percent; and

''(ii) the percentage elected by the individual under subparagraph (A).

''(2) An individual shall elect the option under this subsection in accordance with regulations prescribed by the Commissioner of Social Security.

''(3) The monthly benefit payable to an individual under paragraph (1)(A) shall be subject to reduction as provided in subsection (q).''.

(b) CONFORMING AMENDMENT.—Section 202(a) of the Social Security Act (42 U.S.C. 402(a)) is amended in the last sentence, by striking ''subsection (q) and subsection (w)'' and inserting ''subsections (q), (w), and (z)''.

SEC. 3108. COVERAGE OF NEWLY HIRED STATE AND LOCAL EMPLOYEES.

(a) AMENDMENTS TO THE SOCIAL SECURITY ACT.—

(1) IN GENERAL.—Paragraph (7) of section 210(a) of the Social Security Act (42 U.S.C. 410(a)(7)) is amended to read as follows:

''(7) Excluded State or local government employment (as defined in subsection (s));''.

(2) EXCLUDED STATE OR LOCAL GOVERNMENT EMPLOYMENT.—

(A) IN GENERAL.—Section 210 of such Act (42 U.S.C. 410) is amended by adding at the end the following new subsection:

''(s) EXCLUDED STATE OR LOCAL GOVERNMENT EMPLOYMENT.—(1) IN GENERAL.—The term 'excluded

State or local government employment' means any service performed in the employ of a State, of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, if—

''(A)(i) such service would be excluded from the term 'employment' for purposes of this title if the preceding provisions of this section as in effect in December 2020 had remained in effect, and (ii) the requirements of paragraph (2) are met with respect to such service, or

''(B) the requirements of paragraph (3) are met with respect to such service.

''(2) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to service for any employer if—

''(i) such service is performed by an individual—

''(I) who was performing substantial and regular service for remuneration for that employer before January 1, 2021,

''(II) who is a bona fide employee of that employer on December 31, 2020, and

''(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph, and

''(ii) the employment relationship with that employer has not been terminated after December 31, 2020.

''(B) TREATMENT OF MULTIPLE AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (A), under regulations (consistent with regulations established under section 3121(t)(2)(B) of the Internal Revenue Code of 1986)—

''(i) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

''(ii) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

''(3) EXCEPTION FOR CERTAIN SERVICES.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to service if such service is performed—

"(i) by an individual who is employed by a State or political subdivision thereof to relieve such individual from unemployment,

"(ii) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

"(iii) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency,

"(iv) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training,

"(v) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during 2021, and the adjusted amount determined under subparagraph (C) for any subsequent year with re-

spect to service performed during such subsequent year, except to the extent that service by such election official or election worker is included in employment under an agreement under section 218, or

''(vi) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 211(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self-employment.

''(B) DEFINITIONS.—As used in this paragraph, the terms 'State' and 'political subdivision' have the meanings given those terms in section 218(b).

''(C) ADJUSTMENTS TO DOLLAR AMOUNT FOR ELECTION OFFICIALS AND ELECTION WORKERS.—For each year after 2021, the Commissioner of Social Security shall adjust the amount referred to in subparagraph (A)(v) at the same time and in the same manner as is provided under section 215(a)(1)(B)(ii) with respect to the amounts referred to in section 215(a)(1)(B)(i), except that—

''(i) for purposes of this subparagraph, 2018 shall be substituted for the calendar year referred to in section 215(a)(1)(B)(ii)(II), and

''(ii) such amount as so adjusted, if not a multiple of $100, shall be rounded to the next higher multiple of $100 where such amount is a multiple of $50 and to the nearest multiple of $100 in any other case.

The Commissioner of Social Security shall determine and publish in the Federal Register each adjusted amount determined under this subparagraph not later than November 1 preceding the year for which the adjustment is made.''.

(B) CONFORMING AMENDMENTS.—

(i) Subsection (k) of section 210 of such Act (42 U.S.C. 410(k)) (relating to covered transportation service) is repealed.

(ii) Section 210(p) of such Act (42 U.S.C. 410(p)) is amended—

(I) in paragraph (2), by striking ''service is performed'' and all that follows and inserting ''service is service described in subsection (s)(3)(A).''; and

(II) in paragraph (3)(A), by inserting ''under subsection (a)(7) as in effect in December 2020'' after ''section''.

(iii) Section 218(c)(6) of such Act (42 U.S.C. 418(c)(6)) is amended—

(I) by striking subparagraph (C);

(II) by redesignating subparagraphs (D) and (E) as subparagraphs (C) and (D), respectively; and

(III) by striking subparagraph (F) and inserting the following:

''(E) service which is included as employment under section 210(a).''.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Paragraph (7) of section 3121(b) of the Internal Revenue Code of 1986 (relating to employment) is amended to read as follows:

''(7) excluded State or local government employment (as defined in subsection (t));''.

(2) EXCLUDED STATE OR LOCAL GOVERNMENT EMPLOYMENT.—Section 3121 of such Code is amended by inserting after subsection (s) the following new subsection:

''(t) EXCLUDED STATE OR LOCAL GOVERNMENT EMPLOYMENT.—

''(1) IN GENERAL.—For purposes of this chapter, the term 'excluded State or local government

employment' means any service performed in the employ of a State, of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, if—

"(A)(i) such service would be excluded from the term 'employment' for purposes of this chapter if the provisions of subsection (b)(7) as in effect in December 2020 had remained in effect, and (ii) the requirements of paragraph (2) are met with respect to such service, or

"(B) the requirements of paragraph (3) are met with respect to such service.

"(2) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to service for any employer if—

"(i) such service is performed by an individual—

"(I) who was performing substantial and regular service for remuneration for that employer before January 1, 2021,

"(II) who is a bona fide employee of that employer on December 31, 2020, and

"(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph, and

"(ii) the employment relationship with that employer has not been terminated after December 31, 2020.

"(B) TREATMENT OF MULTIPLE AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (A), under regulations—

"(i) all agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer, and

"(ii) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

"(3) EXCEPTION FOR CERTAIN SERVICES.—

"(A) IN GENERAL.—The requirements of this paragraph are met with respect to service if such service is performed—

"(i) by an individual who is employed by a State or political subdivision thereof to relieve such individual from unemployment,

"(ii) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

"(iii) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency,

"(iv) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training,

''(v) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $1,000 with respect to service performed during 2021, and the adjusted amount determined under section 210(s)(3)(C) of the Social Security Act for any subsequent year with respect to service performed during such subsequent year, except to the extent that service by such election official or election worker is included in employment under an agreement under section 218 of the Social Security Act, or

''(vi) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 1402(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self-employment.

''(B) DEFINITIONS.—As used in this paragraph, the terms 'State' and 'political subdivision' have the meanings given those terms in section 218(b) of the Social Security Act.''.

(3) CONFORMING AMENDMENTS.—

(A) Subsection (j) of such section 3121 (relating to covered transportation service) is repealed.

(B) Paragraph (2) of section 3121(u) of such Code (relating to application of hospital insurance tax to Federal, State, and local employment) is amended—

(i) in subparagraph (B), by striking ''service is performed'' in clause (ii) and all that follows through the end of such subparagraph and inserting ''service is service described in subsection (t)(3)(A).''; and

(ii) in subparagraph (C)(i), by inserting ''under subsection (b)(7) as in effect in December 2020'' after ''chapter''.

(c) EFFECTIVE DATE.—Except as otherwise provided in this section, the amendments made by this section shall apply with respect to service performed after December 31, 2020.

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.

(a) IN GENERAL.—Section 1143(a)(2) of the Social Security Act (42 U.S.C. 1320b–13(a)(2)) is amended—

(1) in subparagraph (E), by striking ''benefits.'' and inserting ''benefits;''; and

(2) by adding after subparagraph (E) the following new subparagraphs:

''(F) an estimate, as determined by the Commissioner, in consultation with the Secretary of Health and Human Services, on the basis of available records of the Commissioner and projections based on reasonable assumptions, of—

''(i) the present value of potential lifetime aggregate employer, employee, and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance (under title II) and for hospital insurance (under part A of title XVIII);

''(ii) the present value of potential lifetime premiums payable (under parts B and D of title XVIII); and

"(iii) the present value of potential lifetime aggregate retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account under title II and per capita benefits payable under the Medicare program of title XVIII; and

"(G) an estimate, as determined by the Commissioner, in consultation with the Secretary of Health and Human Services, on the basis of available records of the Commissioner and projections based on reasonable assumptions, of the ratio (expressed as a percentage) of—

"(i) the sum of the projected deficit-financed benefits under the old-age, survivors, and disability insurance program with respect to the eligible individual and the projected deficit-financed benefits under part A of the Medicare program under title XVIII with respect to the eligible individual, to

"(ii) projected lifetime earnings of the eligible individual.".

(b) DEFINITIONS.—Section 1143(a) of such Act (42 U.S.C. 1320b–13(a)) is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph:

''(3) For purposes of paragraph (2)(G)—

''(A) The term 'projected deficit-financed benefits' means—

''(i) with respect to an eligible individual in connection with the old-age, survivors, and disability insurance program, the product of—

''(I) the benefits described in subparagraph (F)(ii) of such individual under such program, and

''(II) the ratio of future annual deficits, excluding interest, of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund over the eligible individual's lifetime to future annual outlays from such Trust Funds over such lifetime; and

''(ii) with respect to an eligible individual in connection with the Medicare program under title XVIII, the product of—

''(I) the benefits for hospital insurance (under part A of title XVIII) described in subparagraph (F)(ii) of such individual under such program, and

"(II) the ratio of future annual deficits of the Federal Hospital Insurance Trust Fund over the eligible individual's lifetime to future annual outlays from such Trust Fund over such lifetime.

"(B) The term 'projected lifetime earnings' of the eligible individual means the present value of the potential total wages paid to, and self-employment income derived by, the eligible individual over the eligible individual's lifetime, as determined without regard to the contribution and benefit base under section 230.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to annual statements issued after 2013.

SEC. 3110. RETIREMENT INFORMATION CAMPAIGN.

The Commissioner of Social Security shall establish a public information campaign to provide information and education regarding the implications on personal financial security of early and other retirement decisions and the need for greater retirement savings. The information campaign should be designed to encourage individuals to delay retirement so as to build enhanced levels of social security benefits and personal retirement savings. To the extent the Commissioner of Social Security determines appro-

priate, the information provided through the campaign should utilize behavioral economics approaches, such as structured choice, and other scientific approaches.

TITLE IV—CONVERSION TO CHAINED CPI

SEC. 4101. CONVERSION TO CHAINED CPI.

(a) CONSUMER PRICE INDEX ADJUSTMENTS APPLICABLE TO THE INTERNAL REVENUE CODE PROVISIONS.—

(1) IN GENERAL.—Paragraph (3) of section 1(f) of the Internal Revenue Code of 1986 is amended to read as follows:

''(3) COST-OF-LIVING ADJUSTMENT.—

''(A) IN GENERAL.—For purposes of paragraph (2), the cost-of-living adjustment for any calendar year is—

''(i) for adjustments first beginning before 2014, the product of—

''(I) the CPI fraction for calendar years before 2014, multiplied by

''(II) the Chained CPI fraction for calendar years after 2013,

reduced by 1, and

"(ii) for adjustments first beginning after 2013, the Chained CPI fraction for years after 2013.

"(B) CPI FRACTION FOR CALENDAR YEARS BEFORE 2014.—The CPI fraction for calendar years before 2014 is the fraction—

"(i) the numerator of which is the CPI for the calendar year 2012; and

"(ii) the denominator of which is the CPI for the calendar year 1992.

"(C) CHAINED CPI FRACTION FOR CALENDAR YEARS AFTER 2013.—The Chained CPI fraction for calendar years after 2013 is the fraction—

"(i) the numerator of which is the Chained CPI for the preceding calendar year, and

"(ii) the denominator of which is the Chained CPI for the calendar year 2012.".

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (4) of section 1(f) of such Code is amended to read as follows:

"(4) CPI AND CHAINED CPI FOR ANY CALENDAR YEAR.—For purposes of paragraph (3)—

''(A) CPI.—The CPI for any calendar year is the average of the Consumer Price Index as of the close of the 12-month period ending on August 31 of such calendar year.

''(B) CHAINED CPI.—The Chained CPI for any calendar year is the average of the Chained Consumer Price Index as of the close of the 12-month period ending on August 31 of such calendar year.''.

(B) Paragraph (5) of section 1(f) of such Code is amended to read as follows:

''(5) CONSUMER PRICE INDEX AND CHAINED CONSUMER PRICE INDEX.—For purposes of paragraph (4)—

''(A) CONSUMER PRICE INDEX.—The term 'Consumer Price Index' means the last Consumer Price Index for all urban consumers published by the Department of Labor. For purposes of the preceding sentence, the revision of the Consumer Price Index which is most consistent with the Consumer Price Index for calendar year 1986 shall be used.

''(B) CHAINED CONSUMER PRICE INDEX.—The term 'Chained Consumer Price Index' means the most recent estimate of the Chained

Consumer Price Index for all urban consumers published by the Department of Labor.''.

(C) Subclause (II) of section 36B(b)(3)(A)(ii) of such Code is amended by striking ''consumer price index'' and inserting ''Chained Consumer Price Index (as defined in section 1(f)(5)(B))''.

(D) Subclause (II) of section 36B(f)(2)(B)(ii) of such Code is amended by striking ''by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof'' and inserting ''by substituting 'calendar year 2013' for 'calendar year 2012' in subparagraph (C) thereof''.

(E) Clause (ii) of section 45R(d)(3)(B) of such Code is amended by striking ''determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof''.

(F) Subparagraph (B) of section 125(i)(2) of such Code is amended by striking ''determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof''.

(G) Subclause (II) of section 4980I(b)(3)(C)(v) of such Code is amended by

striking ''for '1992' in subparagraph (B) thereof'' and inserting ''for '2012' in subparagraph (C) thereof''.

(H) Clause (ii) of section 5000A(c)(3)(D) of such Code is amended by striking ''by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof'' and inserting ''by substituting 'calendar year 2015' for 'calendar year 2012' in subparagraph (C) thereof''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2013.

(b) MODIFICATIONS TO COST-OF-LIVING INDEXATION OF SOCIAL SECURITY BENEFITS.—

(1) IN GENERAL.—Section 215(i)(1)(D) of the Social Security Act (42 U.S.C. 415(i)(1)(D)) is amended to read as follows:

''(D) the term 'CPI increase percentage', with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the Chained Consumer Price Index for All Urban Consumers (as published in its initial 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 following 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 Department of Labor.''.

(B) Section 215(i)(4) of the Social Security 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 increases described in section 215(i) of the Social Security Act, and to increases under programs dependent on Social Security cost-of-living adjustments, ef-

fective with the month of December for years after 2012.

(c) ADJUSTMENTS OF PROVISIONS UTILIZING THE CONSUMER PRICE INDEX.—

(1) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in this section, for purposes of determining the amount of any cost-of-living increase or similar adjustment under a Federal program or law effective in the month of December 2013 and thereafter, any such increase for the period for which the percentage change is determined shall be deemed to be, in lieu of the increase otherwise determined under applicable law, the increase determined under such applicable law by substituting the Chained CPI for the CPI.

(2) INCREASES DETERMINED FROM A CONSTANT BASE YEAR.—

(A) IN GENERAL.—In any case in which the amount of a cost-of-living increase effective in the month of December 2012 and thereafter is determined under applicable law by reference to a change in the CPI over a period which is determined by reference to a base period which remains constant from year to year, any such increase for any period shall be deemed to be,

in lieu of the increase otherwise determined under applicable law, the increase, expressed as a percentage increase, equal to the product of—

(i) the CPI fraction prior to 2014; multiplied by

(ii) the Chained CPI fraction after 2013,

reduced by 1.

(B) CPI FRACTION PRIOR TO 2014.—The CPI fraction prior to 2014 is the fraction—

(i) the numerator of which is the CPI for the period, ending with or during 2012, which corresponds to the base period; and

(ii) the denominator of which is the CPI for the base period.

(C) CHAINED CPI FRACTION AFTER 2013.—The Chained CPI fraction after 2013 is the fraction—

(i) the numerator of which is the Chained CPI for the period, ending with or during the year preceding the year in which the determination takes effect, which corresponds to the base period; and

(ii) the denominator of which is the most recently published estimate of the

Chained CPI for the period, ending with or during 2012, which corresponds to the base period.

(3) SPECIAL PROVISIONS AND EXCEPTIONS.—

(A) PROGRAMS TIED TO SOCIAL SECURITY.—Subject to subparagraph (B) and the effective date under subsection (b)(4), this section and the amendments made by this section shall apply to any cost-of-living increase or other adjustment which is determined by reference to an adjustment made under section 215(i) of the Social Security Act (42 U.S.C. 415(i)).

(B) POVERTY LINE.—This subsection shall apply to revisions to the poverty line made pursuant to 42 U.S.C. 9902(2), and any programs for which adjustments or eligibility thresholds are based upon the poverty line as defined in that section.

(4) CPI AND CHAINED CPI.—For purposes of this subsection—

(A) the CPI for any period means the average monthly Consumer Price Index for such period, or a component thereof, as determined under the applicable law in connection with any 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''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to cost-of-living increases effective with the month of December of years after 2012.

TITLE V—PUBLIC DEBT LIMIT

SEC. 5101. INCREASE IN PUBLIC DEBT LIMIT.

Section 3101 of title 31, United States Code, is amended—

(1) in subsection (b)—

(A) by inserting ''the sum of'' after ''shall not be more than'', and

(B) by inserting ''the amount determined under subsection (d)'' before '', outstanding at one time'', and

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

''(d) ADDITIONAL INCREASE.—The amount determined under this subsection is the amount of spending reduction attributable to the The Dollar for Dollar Act of 2012, as estimated by the Office of Management and Budget.''.

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