I

112TH CONGRESS
2D SESSION

H. R. 6645

To amend title XVIII of the Social Security Act to save and strengthen the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 11, 2012

Mr. HERGER introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to save and strengthen the Medicare program.

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 ''Save and Strengthen Medicare Act of 2012''.

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

TITLE I—IMPROVED AND UNIFIED MEDICARE PROGRAM THROUGH CHOICE AND COMPETITION

SEC. 101. NEW UNIFIED ELIGIBILITY AND ENROLLMENT RULES.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

"PART E—UNIFIED MEDICARE WITH CHOICE AND COMPETITION

"Subpart 1—Eligibility; Enrollment

"SEC. 1860E–11. UNIFIED ELIGIBILITY AND ENROLLMENT UNDER PARTS A AND B.

''(a) REQUIRING COVERAGE UNDER BOTH PARTS A AND B.—

''(1) IN GENERAL.—Effective as of the general effective date (as specified in section 1860E–62), except as provided under paragraph (3), no benefits shall be covered under part A or part B for an individual unless the individual is both—

''(A) entitled (or enrolled) for benefits under part A; and

''(B) enrolled under part B.

''(2) CLARIFICATION OF PART A ENROLLMENT REQUIRED TO OBTAIN PART B BENEFITS.—Effective as of the general effective date, except as provided under paragraph (3), an individual who is enrolled under part B and is not entitled to hospital insurance benefits under part A shall be entitled to benefits under part B only if the individual enrolls under part A pursuant to section 1818 or 1818A.

''(3) EXCEPTIONS.—

''(A) CONTINUATION OF TREATMENT OF WORKING BENEFICIARIES.—Paragraphs (1) and (2) shall not apply to an individual with respect to whom the provisions of section 1862(b) apply because of enrollment in a primary plan (as defined for purposes of such section).

''(B) GRANDFATHERED FOR CURRENT PART B ONLY ENROLLEES.—

''(i) IN GENERAL.—Paragraphs (1) and (2) shall not apply to an individual who as of the general effective date is enrolled under part B but is not entitled to benefits (or otherwise enrolled) under part A, so long as the individual does not termi-

nate enrollment under part B or enroll under part A.

''(ii) NEW COST-SHARING APPLIES.—

''(I) IN GENERAL.—Nothing in clause (i) shall be construed to exempt an individual described in such clause from the application of the provisions of subpart 2 (relating to cost-sharing), except that the total amount of expenses incurred by the individual during a year which would constitute incurred expenses for which benefits payable under section 1833(a) are determinable shall be reduced by the deductible described in subclause (II) for such year instead of the deductible described in section 1860E–21.

''(II) APPLICABLE DEDUCTIBLE.—The deductible described in this subclause for 2016, is the deductible that would be applied under section 1833(b) (but for the application of this section and subpart 2) for such year, adjusted by the Secretary to take into account any change in the

monthly actuarial rate under section 1839(a)(1) because of the application of the out-of-pocket limit under section 1860E–23, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) (taking into account the application of the out-of-pocket limit under section 1860E–23) ending with such subsequent year (rounded to the nearest $1).

''(iii) PREMIUM.—In the case of an individual described in clause (i), for 2016 or a subsequent year, instead of the combined monthly premium under section 1860E–32(c), there shall be applied to such individual the monthly premium that would be determined under section 1839 for such year.

''(b) PERMITTING INDIVIDUALS TO OPT OUT OF PART A COVERAGE WITHOUT LOSING SOCIAL SECURITY BENEFITS.—

''(1) IN GENERAL.—The Medicare Choices Commission shall establish—

''(A) a process by which an individual otherwise entitled to benefits under part A may elect (at a time and in a manner specified under the process) to waive such entitlement; and

''(B) a process by which an individual who elects to waive such entitlement may revoke (at a time and in a manner specified under the process) such waiver.

The process under subparagraph (B) shall be coordinated with the enrollment process under section 1837 for part B.

''(2) APPLICATION OF LATE ENROLLMENT PENALTY.—An individual who revokes a waiver under paragraph (1)(B) shall be subject to a late enrollment penalty as applied under section 1860E–32(c)(2)(C).

''(3) NO IMPACT ON TITLE II BENEFITS.—Notwithstanding any other provision of law, an election of an individual to waive entitlement to benefits under part A under paragraph (1)(A) shall not result in any loss of benefits under title II.

''(4) DEEMED OPT OUT.—

''(A) An election of an individual to waive entitlement to benefits under part A under paragraph (1)(A) is also deemed the filing of a notice of termination of benefits under part B pursuant to section 1838(b)(1).

''(B) The termination of benefits under part B pursuant to section 1838(b) is also deemed to be a waiver of any entitlement to benefits under part A.

''(c) SPECIAL OPEN ENROLLMENT PERIOD WITHOUT LATE ENROLLMENT PENALTY FOR CURRENT PART A ONLY OR PART B ONLY ENROLLEES.—Notwithstanding any other provision of law, in the case of an individual who as of the general effective date, is entitled to benefits under part A but not enrolled under part B, or who is enrolled under part B but not entitled to benefits (or enrolled) under part A, beginning as of such date, such individual shall be deemed to be enrolled under part B or part A, respectively, unless such individual elects to be enrolled (or entitled to benefits) under neither of such parts during a special open enrollment period specified by the Medicare Choices Commission. No increase in the monthly premium of an individual pursuant to section 1839(b) or section 1818(c) shall be effected in the case of any such individual who is deemed enrolled under part B or part A pursuant

to the previous sentence with respect to any period prior to the date of such enrollment.

''(d) AUTO ENROLLMENT OF DUAL ELIGIBLE INDIVIDUALS UNDER MEDICARE ADVANTAGE PLANS.—

''(1) IN GENERAL.—Except in the case of a State that has elected the maintenance of effort option described in section 1944(b)(2), in the case of an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section), the Medicare Choices Commission shall establish a process for the enrollment in an MA–PD plan that is a managed care plan under part C that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860E–41(b)(1)(A). If there is more than one such plan available, the Medicare Choices Commission shall enroll such an individual on a random basis among all such plans in the PDP region.

''(2) RIGHT TO DISENROLL.—Nothing in paragraph (1) shall prevent such an individual from declining enrollment in any such plan (and thereby obtaining coverage under Medicare fee-for-service) or from changing enrollment in such a plan to another MA–PD plan.

"SEC. 1860E–12. COORDINATION WITH PART D.

"(a) DEEMED ENROLLMENT UNDER PART D.—

"(1) IN GENERAL.—The Medicare Choices Commission shall establish a process that, beginning as of the general effective date, provides for the enrollment in a prescription drug plan that has a monthly base beneficiary premium that does not exceed the weighted average of premiums for such plans that provide standard prescription drug coverage (as defined in section 1860D–2(b)) with respect to the area involved (on a random basis among all such plans in the applicable PDP region) of each Medicare enrollee (as defined in section 1860E–51) who—

"(A) failed to enroll in such a prescription drug plan during the applicable enrollment or coverage election period under section 1860D–1(b); and

"(B) failed to elect not to enroll in such a prescription drug plan during an applicable opt out period described in paragraph (2).

Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment. Such process shall be carried out in the same manner as the process described in section 1860D–1(b)(1)(C).

''(2) OPT OUT PERIODS.—The process under paragraph (1) shall provide for the opportunity to make an election described in subparagraph (B) of such paragraph during an opt out period that is coordinated with the relevant enrollment or coverage election period under section 1860D–1.

''(3) LATE ENROLLMENT PENALTIES.—In the case of an individual who makes an election described in paragraph (1)(B) and then enrolls in a prescription drug plan, the late enrollment penalty under section 1860D–13(b) shall apply to the monthly beneficiary premium of such individual, except that in applying such section, any reference to the initial enrollment period of such individual shall be deemed to be a reference to the opt out period under paragraph (2) during which the individual elected not to enroll in a prescription drug plan.

''(4) NO LATE ENROLLMENT PENALTY FOR CURRENT FEE-FOR-SERVICE BENEFICIARIES WITHOUT DRUG COVERAGE.—In the case of an individual who is a Medicare enrollee before the date of enactment of this section and who was not enrolled under a prescription drug plan before being enrolled under such a plan pursuant to paragraph (1), there shall be no increase in the base beneficiary premium of an

individual under section 1860D–13 by a late enrollment penalty under subsection (b) of such section with respect to any period prior to the date of such enrollment.

''(b) REFERENCE TO REQUIRED PRESCRIPTION DRUG COVERAGE UNDER PART C.—For provision requiring coverage under MA plans to include prescription drug coverage, see section 1860E–26.''.

(b) LIMITATION ON MEDICAID BENEFITS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

''(ll) LIMITATION ON BENEFITS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—Effective as of the general effective date (as specified in section 1860E–62), except in the case of a State which has elected the option described in section 1944(b)(2), in the case of an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section), notwithstanding any other provision of law, medical assistance shall not be available under this title for any items and services for which payment may be made under title XVIII.''.

(c) MEDICAID MAINTENANCE OF EFFORT AND ALTERNATIVES.—Title XIX of the Social Security Act is

amended by inserting after section 1943 the following new section:

''MAINTENANCE OF EFFORT OPTIONS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS

''SEC. 1944. (a) IN GENERAL.—Effective as of the general effective date (as specified in section 1860E–62), a State shall elect, in a form and manner specified by the Secretary, a maintenance of effort option described in subsection (b). In the case of a State that fails to make such an election, the State shall be deemed to have elected the option described in subsection (b)(3).

''(b) MAINTENANCE OF EFFORT OPTIONS DESCRIBED.—The following are maintenance of effort options described in this subsection for a State, which shall apply to all individuals described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section) for such State:

''(1) CONTRIBUTION TOWARDS OUT-OF-POCKET EXPENSES UNDER A TIER 3 MEDICARE PLAN.—The State establishes a program under which the State makes a contribution to a health investment retirement account established under section 503(b) of the Save and Strengthen Medicare Act of 2012 for each such individual in an amount which—

''(A) is calculated, on an average actuarial basis, to cover at least the remaining expenses

under a plan with a tier 3 benefit level under section 1860E–24(b); and

"(B) is risk-adjusted based upon the actuarial characteristics of the individual involved.

"(2) ENROLLMENT OF DUAL ELIGIBLES IN COMPREHENSIVE MEDICAID MANAGED CARE PLAN.—

"(A) IN GENERAL.—The State enrolls all such individuals in a comprehensive Medicaid managed care plan offered by a managed care entity under section 1932.

"(B) PAYMENT OF SUBSIDY AMOUNT TO STATE.—In the case of a State that elects the option under this paragraph with respect to an individual, the Medicare Choices Commission established under section 1860E–51 shall pay to the State the same amount that the individual would be entitled to have paid as an income-related premium subsidy under section 1860E–41(b)(1)(A) plus the amount that the Medicare Choices Commission estimates would have been paid with respect to the individual under part D (including the actuarial value of subsidy payments under sections 1860D–13 and 1860D–14). Such payment shall be made in appropriate part from the Federal Hospital

Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(C) RELATION TO PART D RULES.—In the case of a State that has elected the option under this paragraph, notwithstanding any other provision of law—

''(i) the coverage provided under this option shall be in lieu of any coverage that may otherwise be provided under part D; and

''(ii) the payment to the State under subparagraph (B) shall be in lieu of any payments otherwise made with respect to such individual under such part.

''(3) STATE CONTRIBUTION AMOUNT AND FEDERAL CONTRIBUTIONS TO HIRAS.—

''(A) IN GENERAL.—The State provides for payment to the Secretary for each month in an amount determined under subparagraph (B)(i) and the Secretary makes a contribution to a health investment retirement account established under section 503(b) of the Save and Strengthen Medicare Act of 2012 for each such

individual in an amount described in subparagraph (C).

"(B) STATE CONTRIBUTION AMOUNT.—

"(i) IN GENERAL.—Subject to clause (iii), the amount determined under this clause for a State for a month in a year is equal to the product described in subparagraph (A) of section 1935(c)(1) for the State for the month.

"(ii) FORM AND MANNER OF PAYMENT.—The provisions of subparagraphs (B) through (D) of section 1935(c)(1) shall apply to payment by a State to the Secretary under this paragraph in the same manner as such subparagraphs apply to payment under section 1935(c)(1)(A).

"(iii) APPLICATION OF DIFFERENT FACTORS.—In applying clause (i), the following shall be substituted under paragraphs (2) and (3) of section 1935(c):

"(I) The base year State Medicaid per capita expenditures for covered part D drugs described in subparagraph (A)(i)(I) of such paragraph (2) shall be deemed to be the per cap-

ita expenditures for Medicare cost-sharing that would apply, with respect to an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section) and the State involved, if such an individual received benefits only under title XVIII (and not the State plan under this title).

''(II) Any reference to expenditures for covered part D drugs or for prescription drug benefits shall be deemed a reference to the expenditures for Medicare cost-sharing described in subclause (I).

''(III) Any reference to 2003 or 2004 shall be deemed a reference to 2014 or 2015, respectively.

''(IV) Any reference to a full-benefit-dual-eligible individual shall be deemed a reference to an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into ac-

count the application of subparagraph (B) of such section).

''(V) The applicable growth factor under section 1935(c)(4) for a year, with respect to a State, shall be the average annual percentage change (to that year from the previous year) of the expenditures of the State under the State plan under title XIX.

''(VI) The factor described in section 1935(c)(5) is deemed to be 90 percent.

''(C) FEDERAL CONTRIBUTIONS TO HIRAS.—For purposes of subparagraph (A), the amount described in this subparagraph, with respect to each such individual described in subparagraph (A), is an amount which—

''(i) is calculated, on an average actuarial basis, to cover the remaining expenses under a plan with a tier 3 benefit level under section 1860E–24(b); and

''(ii) is risk-adjusted based upon the actuarial characteristics of the individual.

''(4) OTHER INNOVATIVE ALTERNATIVES.—

''(A) IN GENERAL.—The State submits to the Secretary, and has approved by the Secretary, an innovative alternative proposal relating to coordinating coverage of such individuals under Medicare and the State plan under title XIX.

''(B) PROCESS FOR REVIEW.—With respect to proposals submitted to the Secretary under subparagraph (A), the Secretary shall approve such a proposal if the State demonstrates with respect to the proposal that—

''(i) there would be no increased cost to the Federal Government if it were approved; and

''(ii) there would be no reduction in the quality of care provided to such individuals if the proposal were approved.''.

(d) CONFORMING AMENDMENTS.—

(1) SECTION 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting '', subject to section 1860E–11(b)'' after ''individual who'';

(B) in subsection (b), in the matter preceding paragraph (1), by inserting '', subject to

section 1860E–11(b)'' after ''individual who''; and

(C) in subsection (c), in the matter preceding paragraph (1), by inserting '', subject to section 1860E–11(a)'' after ''subsection (a)''.

(2) SECTION 226A.—Section 226A(a) of such Act (42 U.S.C. 426–1(a)) is amended, in the matter preceding paragraph (1), by inserting ''and subject to section 1860E–11(b)'' after ''or title XVIII''.

(3) SECTION 1818A.—Section 1818A(a) of such Act (42 U.S.C. 1395i–2a(a)) is amended, in the matter preceding paragraph (1), by inserting '', subject to section 1860E–11(a)'' after ''individual who''.

(4) SECTION 1836.—Section 1836 of such Act is amended, in the matter preceding paragraph (1), by inserting '', subject to section 1860E–11(a)'' after ''individual who''.

(5) SECTION 1932.—Section 1932(a)(2)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)(B)) is amended by striking ''A State'' and inserting ''Except in the case of a State that has elected the maintenance of effort option described in section 1944(b)(2), a State''.

SEC. 102. INCENTIVIZED MEDICARE ELIGIBILITY AT INCREASED AGE.

(a) IN GENERAL.—Section 216 of the Social Security Act (42 U.S.C. 426) is amended by adding at the end the following new subsection:

''(m) MEDICARE ELIGIBILITY AGE DEFINED.—

''(1) IN GENERAL.—In this Act, the term 'Medicare eligibility age' means, in accordance with paragraph (2), 65 years of age, the preferred Medicare age, or any age between 65 years of age and the preferred Medicare age.

''(2) CHOICE.—

''(A) IN GENERAL.—Unless an individual elects otherwise (in a manner specified by the Medicare Choices Commission) the Medicare eligibility age shall be the preferred Medicare age described in subparagraph (B) applicable to such individual.

''(B) PREFERRED MEDICARE AGE.—

''(i) IN GENERAL.—The preferred Medicare age with respect to an individual—

''(I) who attains the age of 65 before January 1, 2016, is 65 years of age;

"(II) who attains the age of 65 after December 31, 2015, and before January 1, 2026, is 65 years of age plus the number of months specified by the Medicare Choices Commission for the preferred age phase-in factor under clause (ii) for the calendar year in which the individual attains the age of 65; and

"(III) who attains the age of 65 during a 10-year period (with the first such period beginning on January 1, 2026), 67 years of age increased by the life expectancy increase factor described in clause (iii) for such 10-year period.

"(ii) PREFERRED AGE PHASE-IN FACTOR.—For each year during the 10-year period beginning with 2016, the Medicare Choices Commission shall specify the preferred age phase-in factor as either 2 or 3 months to be applied under clause (i)(II) for individuals attaining 65 years of age during such year in a manner that results in the preferred Medicare age being in-

creased over such 10-year period in as equivalent increments as possible such that for individuals attaining the age of 65 as of December 31, 2025, such preferred Medicare age will be 67 years of age.

''(iii) LIFE EXPECTANCY INCREASE FACTOR.—The life expectancy increase factor under this clause for a 10-year period is the age, rounded to the nearest month, at which (as estimated by the Medicare Choices Commission based on the most recent information available from the National Center for Health Statistics for the 3rd year beginning before such 10-year period) the average life expectancy of an individual who is eligible to enroll under this title and who has attained 67 years of age is 18 years, except that the application of this clause may not result in a year-to-year increase of more than 2 months or in the preferred Medicare age being less than 67 years of age.

''(C) ENROLLMENT OPTIONS.—The Medicare Choices Commission shall specify a manner and process in which an individual may make

an election described in subparagraph (A) to have the Medicare eligibility age applicable to such individual be an age described in paragraph (1) other than the preferred Medicare age so that such election takes effect in the month in which the individuals attains such age. Such process shall provide for an initial election period and subsequent annual election periods for each age that may be elected for the Medicare eligibility age.

''(D) NOTIFICATION.—The Medicare Choices Commission shall provide for notification of each individual who will be eligible for benefits under title XVIII that the Medicare eligibility age of such individual will be the preferred Medicare age unless the individual elects under subparagraph (C) an earlier age described in paragraph (1).

''(3) PREMIUM.—For provisions relating to premium incentives for deferred Medicare eligibility until the preferred Medicare age see section 1860E–32(c).''.

(b) CONFORMING AMENDMENTS.—

(1) SOCIAL SECURITY ACT.—

(A) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—Section 226 of such Act (42 U.S.C. 426) is amended by striking ''age 65'' each place such term appears and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(B) HOSPITAL INSURANCE BENEFITS FOR THE AGED.—Section 1811 of such Act (42 U.S.C. 1395c) is amended by striking ''age 65'' each place such term appears and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(C) HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY INDIVIDUALS NOT OTHERWISE ELIGIBLE.—Section 1818 of such Act (42 U.S.C. 1395i–2) is amended—

(i) in subsection (a)(1), by striking ''age of 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))'';

(ii) in subsection (d)(1), by striking ''age 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''; and

(iii) in subsection (d)(3), by striking ''65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(D) HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT.—Section 1818A(a)(1) of such Act (42 U.S.C. 1395i–2a(a)(1)) is amended by striking ''the age of 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(E) ELIGIBILITY FOR PART B BENEFITS.—

(i) IN GENERAL.—Section 1836 of such Act (42 U.S.C. 1395o) is amended by striking ''age 65'' each place such term appears and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(ii) ENROLLMENT PERIODS.—Section 1837 of such Act (42 U.S.C. 1395p) is amended by striking ''age 65'' and ''the age of 65'' each place such terms appear and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(iii) COVERAGE PERIOD.—Section 1838 of such Act (42 U.S.C. 1395q) is amended—

(I) in subsection (a), by striking ''age 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(II) in subsection (c), by striking ''the age of 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(iv) AMOUNTS OF PREMIUMS.—Section 1839 of such Act (42 U.S.C. 1395r) is amended by striking ''age 65'' and ''the age of 65'' each place such terms appear and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(F) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE.—Section 1844(a)(1) of such Act (42 U.S.C. 1395w) is amended by striking ''age 65'' each place such term appears and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(G) ELIGIBILITY, ELECTION, AND ENROLLMENT.—The matter following subparagraph (D) of section 1851(e)(4) of such Act (42 U.S.C. 1395w–21(e)(4)) is amended by striking ''age 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(H) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—Section 1853(c)(4)(C)(v) of such Act (42 U.S.C. 1395w–23(c)(4)(C)(v)) is amended by striking ''65 years of age'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(I) PART D PREMIUMS AND LATE ENROLLMENT PENALTY.—Section 1860D–13(b)(7)(B)(i) of such Act (42 U.S.C. 1395w–113(b)(7)(B)(i)) is amended by striking ''age 65'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''.

(J) MEDICARE SECONDARY PAYER.—Section 1862(b) of such Act (42 U.S.C. 1395y(b)) is amended by striking ''age 65'' each place such term appears and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(K) CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.—Section 1882(s) of such Act (42 U.S.C. 1395ss(s)) is amended—

(i) in paragraph (2)(A) by striking ''65 years of age'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))'';

(ii) in paragraph (2)(D) by striking ''65 years of age'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''; and

(iii) in paragraph (3)(B)(vi) by striking ''age 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(L) MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES.—Section 1896(a)(5)(D) of such Act (42 U.S.C. 1395ggg(a)(5)(D)) is amended by striking ''age 65'' and inserting ''medicare eligibility age (as such term is defined in section 216(m))''.

(M) MEDICAID STATE PLAN PROVISIONS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(i) in subsection (a)(10)(A)—

(I) in clause (i)(VIII), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))'';

(II) in clause (ii)(XV), by striking ''at least 16, but less than 65, years of age'' and inserting ''at least 16 years of age but less than the medicare eligibility age (as such term is defined in section 216(m))''; and

(III) in clause (ii)(XX), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))'';

(ii) in subsection (e)(14)(D)(i)(II), by striking ''age 65'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))'';

(iii) in subsection (m)(1), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''; and

(iv) in subsection (aa)(2), by striking ''age 65'' and inserting ''the medicare eli-

gibility age (as such term is defined in section 216(m))''.

(N) MEDICAID MEDICAL ASSISTANCE DEFINITION.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended—

(i) in clause (iii), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''; and

(ii) in the matter following paragraph (29)(B), by striking ''65 years of age'' and inserting ''of medicare eligibility age (as such term is defined in section 216(m))''.

(O) QUALIFIED MEDICARE BENEFICIARY DEFINITION.—Section 1905(p)(2)(C) of the Social Security Act (42 U.S.C. 1396d(p)(2)(C)) is amended by striking ''age 65'' and inserting ''who are the medicare eligibility age (as such term is defined in section 216(m))''.

(P) MEDICAID DEFINITION FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUAL.—Section 1905(q) of the Social Security Act (42 U.S.C. 1396d(q)) is amended by striking ''age 65'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''.

(Q) MEDICAID DEFINITION FOR EMPLOYED INDIVIDUAL WITH A MEDICALLY IMPROVED DISABILITY.—Section 1905(v)(1)(A) of the Social Security Act (42 U.S.C. 1396d(v)(1)(A)) is amended by striking ''16, but less than 65, years of age'' and inserting ''16 years of age, but less than the medicare eligibility age (as such term is defined in section 216(m))''.

(R) LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS UNDER MEDICAID.—Section 1917(c) of the Social Security Act (42 U.S.C. 1396p(c)) is amended—

(i) in paragraph (2)(B)(iv), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''; and

(ii) in paragraph (4)(A), by striking ''age 65'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m))''.

(2) OTHER PROVISIONS OF LAW.—

(A) CONTRACTS FOR HEALTH BENEFITS FOR CERTAIN MEMBERS OF UNIFORMED SERVICES, FORMER MEMBERS, AND DEPENDENTS.—

Section 1086(d)(2)(B) of title 10, United States Code, is amended by striking ''under 65 years of age'' and inserting ''under the medicare eligibility age (as such term is defined in section 216(m) of the Social Security Act)''.

(B) ELIGIBLE INDIVIDUAL DEFINITION FOR EARNED INCOME.—Section 32(c)(1)(A)(ii)(II) of the Internal Revenue Code is amended by striking ''age 65'' and inserting ''the preferred Medicare age (as such term is described in section 216(m) of the Social Security Act)''.

(C) TAX TREATMENT OF BLUE CROSS AND BLUE SHIELD ORGANIZATIONS.—Section 833(c)(3)(A)(iv) of the Internal Revenue Code is amended by striking ''age 65'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m) of the Social Security Act)''.

(D) COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.—Section 4202 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–14) is amended—

(i) in subsection (a)—

(I) in paragraph (1), by striking ''who are between 55 and 64 years of age'' and inserting ''who are at least 55 years of age but less than the medicare eligibility age (as such term is defined in section 216(m) of the Social Security Act)'';

(II) in paragraph (2)(C), by striking ''the 55-to-64 year-old population'' and inserting ''the population of individuals who are at least 55 years of age but less than the medicare eligibility age (as such term is defined in section 216(m) of the Social Security Act)'';

(III) in paragraph (3)(A), by striking ''who are between 55 and 64 years of age'' and inserting ''who are at least 55 years of age but less than the medicare eligibility age (as such term is so defined)'';

(IV) in paragraph (3)(C)(i), by striking ''who are between 55 and 64 years of age'' and inserting ''who are at least 55 years of age but less than

the medicare eligibility age (as such term is so defined)''; and

(V) in paragraph (3)(D), by striking ''between 55 and 64 years of age'' and inserting ''at least 55 years of age but less than the medicare eligibility age (as such term is so defined)''; and

(ii) in subsection (b)(2)(A), by striking ''65 years of age'' and inserting ''the medicare eligibility age (as such term is defined in section 216(m) of the Social Security Act)''.

SEC. 103. NEW BENEFIT STRUCTURE UNDER UNIFIED MEDICARE.

(a) IN GENERAL.—Part E of title XVIII of the Social Security Act, as added by section 101, is amended by adding at the end the following:

''Subpart 2—Benefits

''SEC. 1860E–21. UNIFIED PART A AND B DEDUCTIBLE.

''(a) IN GENERAL.—Effective as of the general effective date, in the case of a Medicare enrollee—

''(1) the amount otherwise payable under part A and the total amount of expenses incurred by the enrollee 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 under sections 1813(b) and 1833(b) by the amount of the unified deductible under subsection (b); and

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

''(b) AMOUNT OF UNIFIED DEDUCTIBLE.—

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

''(A) for 2016, $550; or

''(B) for a subsequent year, the amount specified in this subsection for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

''(2) ROUNDING.—If any amount determined under paragraph (1) is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(c) APPLICATION.—The unified deductible under this section for a year shall be applied, with respect to a Medicare enrollee—

''(1) with respect to benefits under part A, on the basis of the amount that is payable for such ben-

efits without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance;

''(2) with respect to benefits under part B, on the basis of the total amount of the expenses incurred by the enrollee during a year which would, except for the application of the deductible, constitute incurred expenses from which benefits payable under section 1833(a) are determinable, without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance;

''(3) instead of the deductibles described in sections 1813(b) and 1833(b); and

''(4) with respect to all items and services under parts A and B.

''SEC. 1860E–22. UNIFORM COINSURANCE.

''(a) IN GENERAL.—Subject to subsection (c) and section 1860E–23, with respect to a year (beginning with 2016), in the case of a Medicare enrollee (as defined in section 1860E–61(b))—

''(1) the amount otherwise payable under part A and the total amount of expenses incurred by the enrollee during the year which would (except for this section) constitute incurred expenses for which bene-

fits payable under section 1833(a) are determinable, shall be reduced by a uniform coinsurance of 20 percent of such amount; and

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

''(b) APPLICATION TO ALL ITEMS AND SERVICES.—The uniform coinsurance under this subsection for a year shall, subject to subsection (d)—

''(1) be applied with respect to items and services under part A on the basis of the amount that is payable for such items and services and in lieu of any other copayments or coinsurance under such part;

''(2) be applied with respect to items and services under part B on the basis of the total amount of the expenses incurred by the individual during the year which would, except for the application of the deductible, constitute incurred expenses from which items and services payable under section 1833(a) are determinable, and in lieu of any other copayments or coinsurance.

''(c) APPLICATION OF DEDUCTIBLE.—Before applying subsection (a), with respect to payment under part A or B for items and services furnished to an individual,

such individual shall be required to meet the unified deductible under section 1860E–21.

''(d) AUTHORITY TO APPLY ACTUARIALLY EQUIVALENT COPAYMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may provide for the application of a copayment amount instead of the coinsurance under this section in cases for which the coinsurance cannot be readily computed at the time of provision of the items or services involved or the imposition of a copayment amount would simplify the administration of this title.

''(2) ACTUARIAL EQUIVALENCE.—In applying paragraph (1), the amount of any copayment established under such paragraph with respect to a type of item or service shall be calculated to provide, in the aggregate and taking into account the application of this section, for cost-sharing that is actuarially equivalent to the cost-sharing that would be imposed under this section if this subsection did not apply.

''SEC. 1860E–23. OUT-OF-POCKET LIMIT.

''(a) IN GENERAL.—Beginning with 2016, in the case of a Medicare enrollee, if the amount of the out-of-pocket cost-sharing of such enrollee for a calendar year equals

or exceeds the catastrophic limit under subsection (b) for that year—

"(1) the enrollee shall not be responsible for additional out-of-pocket cost-sharing incurred during that year; and

"(2) the Secretary shall establish procedures under which the Secretary shall, in appropriate part from the Part A Medicare FFS Account under section 1817 and the Part B Medicare FFS Account under section 1841—

"(A) pay on behalf of the enrollee the amount of the additional out-of-pocket cost-sharing described in paragraph (1) attributable to deductibles and coinsurance described in subsection (c)(1); and

"(B) reimburse the enrollee the amount of the additional out-of-pocket cost-sharing described in paragraph (1) attributable to deductibles and coinsurance described in subsection (c)(2).

"(b) CATASTROPHIC LIMIT.—The amount of the catastrophic limit under this subsection for a year shall be the dollar amount in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only coverage for taxable years beginning in such year.

''(c) OUT-OF-POCKET COST-SHARING DEFINED.—In this section, the term 'out-of-pocket cost-sharing' means, with respect to an individual, the amount of costs incurred by the individual that are attributable to—

''(1) deductibles and coinsurance imposed under sections 1860E–21 and 1860E–22; and

''(2) deductibles and coinsurance imposed under standard prescription drug coverage pursuant to section 1860D–2(b) or alternative prescription drug coverage pursuant to section 1860D–2(c) offered by a prescription drug plan.

"SEC. 1860E–24. OFFERING OF TIERED COST-SHARING COVERAGE LEVELS INSTEAD OF MEDIGAP.

''(a) RECOGNITION OF 3 TIERS OF COST-SHARING COVERAGE.—For plans years beginning on or after the general effective date, MA plans shall be classified based upon the following 3 tiers of cost-sharing coverage (each in this part referred to as a 'tier of cost-sharing coverage'):

''(1) TIER 1.—A tier 1 level (in this part referred to as 'tier 1') for Medicare Advantage plans with cost-sharing designed to provide benefits that are actuarially equivalent to that provided under Medicare fee-for-service.

''(2) TIER 2.—A tier 2 level (in this part referred to as 'tier 2') for Medicare Advantage plans

with cost-sharing designed to provide benefits that would provide a level of coverage of at least 85 percent of the expenses under Medicare fee-for-service for the average Medicare enrollee.

''(3) TIER 3.—A tier 3 level (in this part referred to as 'tier 3') for Medicare Advantage plans with cost-sharing designed to provide benefits that would provide a level of coverage of at least 95 percent of the expenses under Medicare fee-for-service for the average Medicare enrollee.

For purposes of this Act, Medicare fee-for-service shall be included in tier 1.

''(b) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

''(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA AND TIER.—

''(A) IN GENERAL.—The Medicare Choices Commission shall ensure that there is available, consistent with subparagraph (B), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) for each tier of cost-sharing coverage and each MA region.

''(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to a re-

gion if only one entity offers all the qualifying plans in the region.

''(C) QUALIFYING PLAN DEFINED.—For purposes of this section, the term 'qualifying plan' means—

''(i) with respect to tier 1, Medicare fee-for-service or any MA–PD plan that is not classified under tier 2 or tier 3; or

''(ii) with respect to any other tier, an MA–PD plan that is classified under the respective tier.

''(2) FALLBACK PLAN.—In order to ensure access pursuant to paragraph (1) in an MA region, with respect to the offering of plans in a tier, if such access is not provided in such region, the Medicare Choices Commission shall direct the Secretary to provide for the offering of a fallback plan in such tier for that region in a similar manner that the Secretary provides for the offering of a fallback prescription drug plan under section 1860D–11(g) in an area that does not provide access described in section 1860D–3(a).

''(c) MEDIGAP.—

''(1) LIMITATION ON NEW ENROLLMENT.—Subject to paragraph (2), a health insurance issuer that

offers a Medicare supplemental health insurance policy (as defined in section 1882(g)(1)) may not enroll an individual under such policy on or after the general effective date.

"(2) TREATMENT OF CURRENT MEDIGAP ENROLLEES.—

"(A) PERMITTED TO CONTINUE UNDER MEDIGAP.—In the case of an individual who, as of the day before the general effective date is entitled to benefits under part A or enrolled under part B and is enrolled under a Medicare supplemental health insurance policy certified under section 1882, such individual may choose to remain enrolled under such policy or disenroll and change enrollment to a different policy so certified during a period and in accordance with a process specified by the Secretary.

"(B) TREATMENT OF MEDIGAP POLICIES.—

"(i) IN GENERAL.—With respect to plan years beginning on or after January 1, 2016, a Medicare supplemental health insurance policy shall be certified under section 1882 only with respect to individ-

uals described in subparagraph (A) and only if such policy is modified to be in accordance with standards revised pursuant to clause (ii).

''(ii) NEW STANDARDS.—The Secretary shall request the National Association of Insurance Commissioners to revise the standards for all benefit packages for Medicare supplemental health insurance policies under section 1882(p) to be in accordance with the cost-sharing provisions established by this subpart.

''(C) AVAILABILITY OF SUBSTITUTE POLICIES WITH GUARANTEED ISSUE.—

''(i) IN GENERAL.—The issuer of a medicare supplemental policy—

''(I) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that is offered and is available for issuance to new enrollees by such issuer;

''(II) may not discriminate in the pricing of such policy, because of health status, claims experience, re-

ceipt of health care, or medical condition; and

''(III) may not impose an exclusion of benefits based on a pre-existing condition under such policy, in the case of an individual described in clause (ii) who seeks to enroll under the policy during a period described in subparagraph (A).

''(ii) INDIVIDUAL COVERED.—An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

''(I) is described in subparagraph (A) and, as of the date described in such subparagraph, is enrolled under a medicare supplemental policy; and

''(II) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A) during the period described in such subparagraph.

''(iii) LIMITATION.—Subclause (i) shall apply to an issuer of a medicare sup-

plemental policy, with respect to an individual, only in the case the actuarial value of the benefits under such policy does not substantially exceed the actuarial value of the policy described in clause (ii)(II) with respect to which the individual terminated enrollment.

"SEC. 1860E–25. CONTRIBUTIONS INTO HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.

"(a) CONTRIBUTIONS.—The Secretary shall establish procedures to ensure that, for each year (beginning with 2016), the Secretary shall deposit in the health individual retirement account (as defined in section 201(1) of the Save and Strengthen Medicare Act of 2012) of an account holder (as defined in section 201(2) of such Act) who is a Medicare fee-for-service enrollee the per capita Medicare preventive benefit amount under subsection (b) for such year. In no case shall a deposit be made under the previous sentence in the case of an individual described in subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section) in a State that has elected the maintenance of effort option described in section 1944(b)(2).

"(b) PER CAPITA MEDICARE PREVENTIVE BENEFIT AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (b), the per capita Medicare preventive benefit amount is equal to—

''(A) with respect to 2016, the amount by which—

''(i) the average per capita amount estimated to have been expended under Medicare fee-for-service for preventive services during the previous year; exceeds

''(ii) the average per capita amount that would have been expended under Medicare fee-for-service for such services during such previous year if payment under Medicare fee-for-service for such services had been subject to the deductible and cost-sharing provisions of section 1833;

''(B) with respect to 2017, the amount by which—

''(i) the actual average per capita amount expended under Medicare fee-for-service for preventive services during 2015; exceeds

''(ii) the average per capita amount that would have been expended under

Medicare fee-for-service for such services during such year if payment under Medicare fee-for-service for such services had been subject to the deductible and cost-sharing provisions of section 1833;

increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; and

"(C) with respect to a subsequent year, the amount determined under this paragraph for the previous year, increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

"(2) PREVENTIVE SERVICES.—For purposes of this section, the term 'preventive services' means preventive services that are exempt from coinsurance under section 1833(a)(1)(Y) for 2015.

"(c) PAYMENT.—

"(1) FROM CMS OPERATING ACCOUNT.—Payment of each per capita Medicare preventive benefit amount shall be made in appropriate part from the Part A Medicare FFS Account under section 1817

and the Part B Medicare FFS Account under section 1841.

''(2) AVAILABILITY.—Payment of a per capita Medicare preventive benefit amount for a year to the health individual retirement account of an individual shall be made available to such account only for such year. If, by December 31 of such year, the amount of the per capita Medicare preventive benefit amount deposited for such year exceeds the amount distributed from the account of the individual (in accordance with section 206(a) of the Save and Strengthen Medicare Act of 2012) during such year, such excess shall be returned to the Medicare FFS Account in accordance with procedures established under subsection (e).

''SEC. 1860E–26. REQUIRING MA PLANS TO OFFER PRESCRIPTION DRUG COVERAGE.

''Beginning for plan years beginning on or after the general effective date, the only MA plans that may be offered under part C are MA–PD plans.''.

(b) APPLICATION OF OUT-OF-POCKET LIMIT TO MA–PD PLANS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iii)'' and inserting ''clauses (iii) and (vi)''; and

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

''(vi) OUT-OF-POCKET LIMIT.—The provisions of section 1860E–23—

''(I) shall apply to individuals enrolled under an MA–PD plan in the same manner as such provisions apply to Medicare enrollees under such section, except that in lieu of the application of subsection (a)(2) of such section the MA–PD plan shall establish procedures to provide for payment of any additional out-of-pocket cost-sharing described in subsection (a)(1) of such section incurred by individuals enrolled under the MA–PD plan; and

''(II) as applied under subclause (I), may not be waived by application of this subparagraph.

In applying subsection (b) of section 1860E–23 pursuant to the previous sentence, an MA–PD plan may substitute a

dollar amount that is less than the dollar amount specified under such subsection.''.

(2) EXEMPTING MA–PD PLANS OFFERING ALTERNATIVE PRESCRIPTION DRUG COVERAGE FROM PART D DEDUCTIBLE AND OUT-OF-POCKET LIMIT REQUIREMENTS.—Section 1860D–2(c) of the Social Security Act (42 U.S.C. 1395w–102(c)) is amended—

(A) in paragraph (2), by striking ''The deductible'' and inserting ''In the case of a prescription drug plan, the deductible''; and

(B) in paragraph (3), by striking ''The coverage provides'' and inserting ''In the case of a prescription drug plan, the coverage provides''.

(c) PRESCRIPTION DRUG PLANS REQUIRED TO REPORT ENROLLEES' OUT-OF-POCKET COST-SHARING.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) OUT-OF-POCKET COST-SHARING REPORTS.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall require that, with respect to each claim submitted for items

or services furnished to an individual enrolled under the plan pursuant to the contract, the sponsor submits to the Secretary information on the amount of out-of-pocket cost-sharing (as defined in section 1860E–23(c)) applicable to such enrollee for such items or services.''.

(d) 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 subpart 2 of part E:'' before paragraph (1); and

(B) in subsection (b), by inserting ''Subject to subpart 2 of part E:'' before paragraph (1).

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

(A) in subsection (a), in the matter preceding paragraph (1), by inserting ''and subpart 2 of part E'' after ''succeeding provisions of this section'';

(B) in subsection (b), in the first sentence, by striking ''Before applying'' and inserting ''Subject to subpart 2 of part E, before applying'';

(C) in subsection (c)(1), in the matter preceding subparagraph (A), by inserting ''subject to subpart 2 of part E,'' after ''this part,'';

(D) in subsection (f), by striking ''In establishing'' and inserting ''Subject to subpart 2 of part E, in establishing''; and

(E) in subsection (g)(1), by inserting ''and subpart 2 of part E'' and ''paragraphs (4) and (5)''.

(3) Section 1882(a)(2) of such Act is amended by striking ''No medicare'' and inserting ''Subject to section 1860E–24(c), no medicare''.

SEC. 104. LATE ENROLLMENT PENALTY NOT TO APPLY FOR MONTHS OF ANY HEALTH COVERAGE.

(a) IN GENERAL.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r) is amended in the second sentence, by inserting before the period at the end the following: ''or months during which the individual has any other health coverage''.

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for months of coverage beginning after the date of the enactment of this Act.

SEC. 105. COMPETITIVE BIDDING AND PREMIUMS UNDER UNIFIED MEDICARE.

(a) IN GENERAL.—Part E of title XVIII of the Social Security Act, as added by section 101 and amended by section 103, is further amended by adding at the end the following:

"Subpart 3—Competitive Bidding and Premiums

"SEC. 1860E–31. APPLICATION OF COMPETITIVE BIDDING AND CHANGES IN PREMIUMS.

"(a) COMPETITIVE BIDDING BASED ON LEVELS OF COVERAGE AND MA REGIONS.—In applying section 1854 for plan years beginning on or after the general effective date the following rules shall apply:

"(1) SEPARATE BIDS FOR EACH TIER OF COST-SHARING COVERAGE.—A Medicare Advantage organization shall submit a separate bid for each tier of cost-sharing coverage for each MA–PD plan offered by such organization.

"(2) BIDS.—Any bid submitted by a Medicare Advantage organization under such section—

"(A) with respect to an MA region, shall provide for the offering of an MA–PD plan in each county within such region; and

"(B) with respect to an MA local area, shall provide for the offering of an MA–PD plan in each county within such area.

''(3) UNIFORM BIDS FOR ALL AREAS WITHIN AN MA REGION.—Any bid submitted by a Medicare Advantage organization under such section shall, as specified by the organization, be uniform for—

''(A) all plans offered in any MA local area within an MA region; or

''(B) subject to paragraph (4), all plans offered within a county; and

section 1854(h) shall apply.

''(4) AUTHORITY OF MEDICARE CHOICES COMMISSION TO REJECT BIDS.—In the case that the Medicare Choices Commission determines that a Medicare Advantage organization is submitting bids in accordance with paragraph (3)(B) in a manner that demonstrates a disproportionate change in the amounts of the bids for such areas compared to the actual costs for providing benefits in such areas, the Commission may reject such bids.

''(5) ACCEPTANCE OF BID.—

''(A) IN GENERAL.—A Medicare Advantage organization shall not be eligible to submit a bid under such section unless the organization provides assurances satisfactory to the Medicare Choices Commission that the organization will

accept an award of a contract under this part pursuant to such bid.

''(B) CERTAIN MODIFICATIONS PERMITTED.—Nothing in subparagraph (A) shall be construed as preventing a Medicare Advantage organization that submits a bid under such section from withdrawing or modifying the bid before the date on which the risk-adjusted benchmark amount under paragraph (3)(B)(i) or (4)(B)(i), as appropriate, of section 1854(b) is calculated for the area and year involved.

''(b) ADJUSTMENT IN PAYMENT TO MA PLANS.—

''(1) IN GENERAL.—In applying section 1853 for plans years beginning on or after the general effective date, the amount specified in subparagraph (B) of section 1853(a)(1) shall be 1/12 of 88 percent of the revised benchmark for the region and year involved.

''(2) REVISED BENCHMARK.—

''(A) IN GENERAL.—The Medicare Choices Commission shall compute a revised benchmark for each plan year and each MA region.

''(B) REVISED BENCHMARK.—Subject to the succeeding provisions of this paragraph, the

revised benchmark for a plan year and MA region is equal to the sum of—

"(i) the phase-out percentage (as specified in subparagraph (C)) of the average of the lowest and third lowest bid amount submitted for such year and region for the tier 1 level of cost-sharing coverage under section 1860E–24(b), taking into account section 1860E–32(b); and

"(ii) the phase-in percentage (as specified in subparagraph (C)) of the lowest bid amount so submitted.

"(C) PHASE OUT AND PHASE-IN PERCENTAGES.—In subparagraph (B), with respect—

"(i) to the first plan year in which this section applies, the phase-out percentage shall be 100 percent and the phase-in percentage shall be 0 percent; and

"(ii) each succeeding plan year the phase-out percentage shall be the phase-out percentage for the previous year decreased by 20 percentage points (but not below 0 percent) and the phase-in percentage shall be 100 percent minus the phase-out percentage for the year.

"(D) LIMITATION.—In no case shall the revised benchmark for a plan year and MA region be lower than the lowest bid amount submitted for such year and region that when combined with all bids below such bid amount would result in the capacity to provide coverage to all Medicare enrollees in such region.

"(3) REVIEW AND REVISIONS OF RISK ADJUSTMENT.—

"(A) IN GENERAL.—The Medicare Choices Commission shall review and, as the Commission determines appropriate, revise the risk adjustments payment mechanism under section 1853(a)(1)(C) for purposes of applying such mechanism under this section and under section 1860E–32, including pursuant to section 1860E–33(a).

"(B) REQUIREMENTS FOR REVISIONS.—In making the revisions under subparagraph (A) to the risk adjustments payment mechanism described in such subparagraph, the following shall apply:

"(i) INCORPORATING PRIVATE HEALTH INSURANCE DATA.—The Medicare Choices Commission shall incorporate data

on the cost and utilization of services by individuals receiving benefits under a group health plan or health insurance coverage offered in the individual or group market who have the same case characteristics (such as conditions or combinations of conditions) as such characteristics that are to be used under such mechanism for risk adjusting payment amounts to Medicare Advantage organizations under part C and Medicare fee-for-service under section 1860E–32, including pursuant to section 1860E–33(a).

''(ii) INCLUSION OF NUMBER OF CONDITIONS.—The Medicare Choices Commission shall provide that a risk score under such mechanism, with respect to an individual, includes an indicator for the number of chronic conditions with which the individual has been diagnosed.

''(iii) USE OF 2 YEARS OF DIAGNOSIS DATA.—The Medicare Choices Commission shall ensure that a risk score under such mechanism, with respect to an individual,

shall reflect two years of diagnosis data, to the extent available.

''(C) EVALUATING ADDITION OF RETROSPECTIVE RISK TRANSFER POOL.—In conducting the review under subparagraph (A) of the risk adjustments payment mechanism described in such subparagraph, the Medicare Choices Commission shall evaluate the extent to which it would be appropriate to establish, in addition to such risk adjustments payment mechanism, a retrospective risk transfer pool—

''(i) that would enable MA organizations, with respect to MA–PD plans offered by such organization, and the Secretary, with respect to Medicare fee-for-service, to collectively devise and administer procedures for adjusting for enrollee selection effects that are not, in the judgment of the organizations, with respect to such plans, and the Secretary, with respect to Medicare fee-for-service, adequately addressed by the risk adjustments payment mechanism;

''(ii) under which each MA–PD plan and Medicare fee-for-service must participate;

''(iii) which shall be operated by the MA organizations offering such MA–PD plans and the Secretary under the supervision of the Medicare Choices Commission; and

''(iv) which would be funded entirely out of premiums and assessments on such plans and Medicare fee-for-service.

''(4) APPLICATION ON A REGIONAL BASIS.—In applying sections 1853 and 1854, the revised benchmark under this subsection for each MA local area within an MA region shall be the revised benchmark for such region.

''(c) PREMIUMS UNDER MA PLANS.—

''(1) IN GENERAL.—For plans years beginning on or after the general effective date, sections 1853 and 1854 shall be applied—

''(A) by substituting the modified monthly basic beneficiary premium described in paragraph (2)(A) for the MA monthly basic beneficiary premium defined in section 1854(b)(2)(A); and

''(B) by substituting the revised benchmark under subsection (b) for the unadjusted MA area specific non-drug monthly benchmark amount (as defined in section 1853(j)).

''(2) MODIFIED MONTHLY BASIC BENEFICIARY PREMIUM.—

''(A) IN GENERAL.—The modified monthly basic beneficiary premium described in this paragraph, with respect to a month in a year and an MA plan offered in a tier of cost-sharing coverage in an MA region, is the amount (if any) by which the MA non-drug bid described in subparagraph (B) for such plan exceeds 1/12 of the revised benchmark described in subsection (b) for the year and region.

''(B) MA NON-DRUG BID.—The MA non-drug bid described in this subparagraph is, with respect to a month and an MA plan offered in a tier of cost-sharing coverage, the portion of the bid amount submitted under clause (i) of section 1854(a)(6)(A) for the tier benefit level, MA region, and year involved that is attributable under clause (ii)(I) of such section to the provision of benefits under Medicare fee-for-service.

"(3) APPLICATION ON A REGIONAL BASIS.—In applying sections 1853 and 1854, the average per capita monthly savings under section 1854(b)(3) shall be computed by substituting each region for a State and all plans within the region for MA local plans within a State.

"(4) TREATMENT OF BENEFICIARY REBATE RULE.—Section 1854(b)(1)(C) shall not apply to the modified monthly basic beneficiary premium applied under this subsection.

"(5) TREATMENT OF INDIVIDUALS ELECTING EARLIER BENEFIT COVERAGE.—Section 1860E–32(c)(3) shall apply to an MA organization and the premium charged under section 1854(b)(1) to an individual enrolled in an MA plan offered by such organization who makes an election described in such section 1860E–32(c)(3) in the same manner as such section applies to the Secretary and an individual enrolled under Medicare fee-for-service who makes such an election.

"(d) ANNUAL REPORT.—Beginning for 2016, the Medicare Choices Commission shall submit to Congress an annual report on any questionable activities or irregularities that have arisen in the bidding process under part C, as modified by this section, during such year.

"SEC. 1860E–32. APPLICATION OF COMPETITIVE BIDDING TO MEDICARE FEE-FOR-SERVICE.

''(a) SUBMISSION OF BID.—

''(1) IN GENERAL.—The Secretary shall submit a bid for Medicare fee-for-service (in this part referred to as a 'Medicare FFS bid') offered for each MA region in the same manner as a bid submitted by a Medicare Advantage organization under section 1854 for offering an MA plan under such tier.

''(2) BASIS FOR BID.—In applying paragraph (1) in computing the average revenue requirements under section 1854(a)(6)(A)(i) for a plan year, the Secretary shall base such requirements on—

''(A) adjusted average per capita costs payable during the previous plan year under parts A and B attributable to all individuals enrolled under Medicare fee-for-service in such region, including administrative costs attributable to such individuals and costs attributable to such individuals with respect to per capita Medicare preventive benefit amounts contributed under section 1860E–25 into health individual retirement accounts, (as estimated by the Secretary), increased by

''(B) the Secretary's estimate of the percentage increase in the per capita actuarial

value of benefits under such parts for the plan year involved.

''(3) MODIFICATION.—In applying this subsection, clause (iii) of section 1854(a)(6)(B) shall not be construed as applying to Medicare fee-for-service.

''(b) TREATMENT OF BID AS A TIER 1 BID UNDER PART C.—Any bid under subsection (a) for a region shall be considered as a bid for an MA plan offered in the region with tier 1 cost-sharing coverage for purposes of this part and sections 1853 and 1854.

''(c) PREMIUMS ADJUSTMENT.—

''(1) IN GENERAL.—Beginning for months beginning on or after the general effective date—

''(A) there shall be a combined monthly premium amount described in paragraph (2) charged to a Medicare enrollee, with respect to coverage under Medicare fee-for-service;

''(B) such premium amount under subparagraph (A) shall be instead of the part B monthly premium under section 1839; and

''(C) such premium shall be separate from (and in addition to) any monthly beneficiary premium that may apply to the individual with

respect to a prescription drug plan under part D.

"(2) COMBINED MONTHLY PREMIUM.—

"(A) IN GENERAL.—The combined monthly premium amount under this paragraph for a Medicare enrollee in an MA region shall be, subject to subparagraph (D) and section 1860E–41(b), equal to the combined monthly base amount under subparagraph (B), adjusted in accordance with subparagraphs (C) and (D).

"(B) COMBINED MONTHLY BASE AMOUNT.—The combined monthly base amount shall be an amount calculated in a manner similar to the manner in which the part B monthly premium is calculated under subsections (a) and (c) of section 1839, in effect as of December 31, 2015, except that in applying such section—

"(i) the actuarial rate determined under the second sentence of subsection (a)(1) of such section shall be an amount the Secretary estimates to be necessary so that the aggregate amount for the calendar year involved with respect to all Medicare enrollees will equal the total of the benefits

and administrative costs which the Secretary estimates will be payable from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 for services performed and related administrative costs incurred in such calendar year with respect to such enrollees under parts A and B; and

''(ii) by substituting '24 percent' for '50 percent' in subsection (a)(3) of such section.

''(C) APPLICATION OF OTHER PROVISIONS.—The combined monthly base amount shall be subject to adjustment in the same manner as the part B monthly premium calculated under section 1839(a) is subject to adjustment under subsections (b) and (i) of such section, except that—

''(i) in applying the late enrollment penalty under subsection (b) of such section, the initial enrollment period of the individual shall be the enrollment period specified by the Secretary pursuant to sub-

part 1 instead of the initial enrollment period described in such section 1839(b); and

"(ii) the income reduction under subsection (i) of such section shall be applied in accordance with section 1860E–41(a).

Adjustments under this subparagraph shall be made without regard to any adjustment under subparagraph (D).

"(D) AMOUNT OF ADJUSTMENT FOR NON-MA ENROLLEES.—Under this subparagraph, with respect to a Medicare fee-for-service enrollee for a month who resides in an MA region, if the Medicare FFS bid under subsection (a) for the region and month exceeds such revised benchmark, the amount of the combined monthly base amount for the enrollee for the month (without regard to any adjustment under subparagraph (C)) shall be increased, subject to subparagraph (E), by the amount by which such bid exceeds such benchmark.

"(E) TRANSITION FOR CURRENT TRADITIONAL FFS MEDICARE BENEFICIARIES.—In the case of an individual who, as of December 31, 2015, is entitled to (or enrolled for) benefits

under part A or enrolled under part B but is not enrolled in an MA plan—

"(i) with respect to months in 2016, the adjustment under subparagraph (D) for such individual for such months may in no case exceed 20 percent of the part B monthly premium amount under section 1839 that was applicable to such individual for months in the previous year; and

"(ii) with respect to months in a subsequent year (before 2026), such adjustment for such months may in no case exceed 20 percent of the combined monthly premium amount applicable to such individual (not taking into account subparagraph (C)) for months in the previous year.

"(3) TREATMENT OF INDIVIDUALS ELECTING EARLIER BENEFIT COVERAGE.—In the case of an individual who elects under section 216(m) a Medicare eligibility age of at least 65 but less than the preferred Medicare age applicable to such individual under paragraph (2)(B) of such section, the Secretary shall adjust the premium otherwise computed for individuals with a Medicare eligibility age of the

preferred Medicare age in a manner so that, on an actuarial basis over the lifetime of individuals making such an election (taking into account the relevant risk characteristics of individuals who as a class have selected the respective age compared to those who have not made the election), the actuarial value of the benefits (net of premiums) is equal among such groups.

''(4) PAYMENT OF PREMIUMS.—The provisions of section 1854(d)(2) shall apply to the payment and collection of combined monthly premium amounts under this subsection in a similar manner as such provisions apply to the payment to and collection by an MA organization of monthly premiums under part C.

''SEC. 1860E–33. ENSURING A LEVEL PLAYING FIELD.

''(a) IN GENERAL.—Except as specified otherwise in this part, the Secretary and Medicare fee-for-service shall be subject to requirements that are applicable under this title to an MA organization and Medicare Advantage plan, and payments shall be made to the Secretary, with respect to coverage of an individual under Medicare fee-for-service in the same manner as payments are made under section 1853(a)(1) to an MA organization, with respect to cov-

erage of an individual under a Medicare Advantage plan offered by such organization.

''(b) ENSURING COLLECTION OF QUALITY AND RISK DATA.—The Medicare Choices Commission shall establish procedures to ensure that quality data and data on risk factors of Medicare enrollees are collected and reported with respect to Medicare fee-for-service in the same manner as such data are collected and reported with respect to Medicare Advantage plans.

''(c) NONINTERFERENCE RULES.—

''(1) NEGOTIATIONS BETWEEN MA PLANS AND PROVIDERS.—In order to promote competition under this title and in carrying out this title, neither the Secretary nor the Medicare Choices Commission may interfere with the negotiations between any MA organization and a hospital, physician, or other provider of services or supplier.

''(2) BIDDING PROCESS.—The Medicare Choices Commission may not reject a bid submitted by an MA organization for the offering of an MA–PD plan based on the amount of such bid. Nothing in the previous sentence shall be construed as affecting the regulatory authority of the Commission or as affecting the authority of the Commission to reject a bid pursuant to section 1860E–31(a)(3).

''(3) TREATMENT OF REGULATORY FUNCTIONS.—

''(A) IN GENERAL.—The Secretary, through the Centers of Medicare & Medicaid Services, shall maintain regulatory functions associated with conditions of participation applicable to participation of providers of services and suppliers in Medicare fee-for-service.

''(B) NO APPLICATION TO PROVIDERS WITH RESPECT TO MA PLANS.—Beginning on the general effective date, the Secretary shall not have the authority to apply any conditions of participation or similar requirements on providers of services and suppliers insofar as they are not related to Medicare fee-for-service.

''(C) GAO REPORT.—By not later than January 31, 2015, the Comptroller General of the United States shall submit to Congress a report containing recommendations on the extent to which any condition of participation or requirement described in paragraph (2) should be applied to providers of services and suppliers furnishing items and services under this title under arrangements with Medicare Advantage plans.

''(d) REPORT.—

''(1) INITIAL REPORT.—Not later than September 30, 2014, the Medicare Choices Commission shall submit to Congress a report that—

''(A) identifies all the requirements that are applicable to MA organizations and Medicare Advantage plans and the extent to which such requirements are also applicable to the Secretary and Medicare fee-for-service; and

''(B) includes a plan for achieving the requirement described in subsection (a).

''(2) GAO REPORTS.—Not later than January 1, 2016, and every 3 years thereafter, the Comptroller General of the United States shall submit to Congress a report on the extent to which the Secretary and Medicare fee-for-service are in compliance with subsection (a) and the plan described in paragraph (1)(B).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1839(a) of the Social Security Act is amended by inserting after the subsection enumerator the following: ''Subject to section 1860E–32:''.

(2) Section 1839(i)(1) of the Social Security Act is amended by striking ''In the case'' and insert-

ing ''Subject to sections 1860E–32 and 1860E–41, in the case''.

(3) Section 1853(a)(1)(A) of the Social Security Act is amended by striking ''and section 1859(e)(4)'' and inserting '', section 1859(e)(4), and subpart 3 of part E''.

(4) Section 1853(j) of such Act is amended by inserting ''and subpart 3 of part E'' after ''subsection (o)''.

(5) Section 1854 of such Act is amended—

(A) in subsection (a), after the heading, by inserting ''Subject to subpart 3 of part E:'';

(B) in subsection (b), after the heading, by inserting ''Subject to subpart 3 of part E:'';

(C) in subsection (d), after the heading, by inserting ''Subject to subpart 3 of part E:''; and

(D) in subsection (e), after the heading, by inserting ''Subject to subpart 3 of part E:''.

SEC. 106. SEPARATE MEDICARE FFS ACCOUNTS AND OTHER FINANCING UNDER UNIFIED MEDICARE.

(a) SEPARATE MEDICARE FFS ACCOUNTS.—

(1) UNDER FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 of the Social Security

Act (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) PART A MEDICARE FFS ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established within the Trust Fund an account to be known as the 'Part A Medicare FFS account' for the receipts and disbursements attributable to the operation of Medicare fee-for-service (as defined in section 1860E–61(b)) insofar as it relates to the program under this part, as modified under part E, including the transition funding under paragraph (2)(B). Section 1854(g) shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

''(2) FUNDING.—

''(A) IN GENERAL.—The Part A Medicare FFS Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), as applied under this section, accrued interest on balances in the Part A Medicare FFS Account, and such amounts as may be deposited in, or appropriated to, such Part A Medicare FFS Account as provided in this subsection.

"(B) TRANSITION FUNDING.—

"(i) IN GENERAL.—In order to provide for funding relating to transitional costs for carrying out Medicare fee-for-service insofar as it relates to the program under this part, as modified under part E, as of the general effective date (as defined in section 1860E–62), there shall be transferred from the Trust Fund to the Part A Medicare FFS Account such sums as specified necessary by the Medicare Choices Commission. In order to provide for initial claims reserves before the collection of premiums, there shall be transferred from the Trust Fund to the Part A Medicare FFS Account such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

"(ii) AMORTIZATION OF TRANSITION FUNDING.—The Secretary shall provide for the repayment to the Trust Fund of the funding transferred under clause (i) in an amortized manner over the 10-year period beginning with the first plan year begin-

ning on or after the general effective date (as defined in section 1860E–62).

''(iii) LIMITATION ON FUNDING.—Nothing in this paragraph shall be construed as authorizing any additional transfers to the Part A Medicare FFS Account, other than such amounts as are otherwise provided with respect to Medicare Advantage plans.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this subsection to the Part A Medicare FFS Account shall—

''(A) be kept separate from all other funds within the Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within the Trust Fund; and

''(B) notwithstanding the previous subsections of this section, be managed and administered by the Administrator of the Centers for Medicare & Medicaid Services.''.

(2) UNDER SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended by adding at the end the following new subsection:

''(j) PART B MEDICARE FFS ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established within the Trust Fund an account to be known as the 'Part B Medicare FFS account' for the receipts and disbursements attributable to the operation of Medicare fee-for-service (as defined in section 1860E–61(b)) insofar as it relates to the program under this part, as modified under part E, including the transition funding under paragraph (2)(B). Section 1854(g) shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

''(2) FUNDING.—

''(A) IN GENERAL.—The Part B Medicare FFS Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), as applied pursuant to this section, accrued interest on balances in the Part B Medicare FFS Account, and such amounts as may be deposited in, or appropriated to, the Part B Medicare FFS Account as provided in this subsection.

''(B) TRANSITION FUNDING.—

"(i) IN GENERAL.—In order to provide for funding relating to transitional costs for carrying out Medicare fee-for-service insofar as it relates to the program under this part, as modified under part E, as of the general effective date (as defined in section 1860E–62), there shall be transferred from the Trust Fund to the Part B Medicare FFS Account such sums as specified necessary by the Medicare Choices Commission. In order to provide for initial claims reserves before the collection of premiums, there shall be transferred from the Trust Fund to the Part B Medicare FFS Account such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

"(ii) AMORTIZATION OF TRANSITION FUNDING.—The Secretary shall provide for the repayment to the Trust Fund of the funding transferred under clause (i) in an amortized manner over the 10-year period beginning with the first plan year beginning on or after the general effective date (as defined in section 1860E–62).

''(iii) LIMITATION ON FUNDING.—Nothing in this paragraph shall be construed as authorizing any additional transfers to the Part B Medicare FFS Account, other than such amounts as are otherwise provided with respect to Medicare Advantage plans.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this subsection to the Part B Medicare FFS Account shall—

''(A) be kept separate from all other funds within the Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within the Trust Fund; and

''(B) notwithstanding the previous subsections of this section, be managed and administered by the the Administrator of the Centers for Medicare & Medicaid Services.''.

(b) CHAIRPERSON OF MEDICARE CHOICES COMMISSION TO REPLACE ADMINISTRATOR OF CMS ON AS SECRETARY OF BOARD OF TRUSTEES OF HI AND SMI TRUST FUNDS.—

(1) HI TRUST FUND.—Section 1817(b) of the Social Security Act (42 U.S.C. 1395i(b)) is amended

by striking ''The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees.'' and inserting ''Before the general effective date defined under section 1860E–62, the Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. On and after such general effective date such Administrator shall not serve as the Secretary of such Board and instead the Chairperson of the Medicare Choices Commission established under section 1860E–51 shall serve as the Secretary of such Board.''.

(2) SMI TRUST FUND.—Section 1841(b) of the Social Security Act (42 U.S.C. 1395t(b)) is amended by striking ''The Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees.'' and inserting ''Before the general effective date defined under section 1860E–62, the Administrator of the Centers for Medicare & Medicaid Services shall serve as the Secretary of the Board of Trustees. On and after such general effective date such Administrator shall not serve as the Secretary of such Board and instead the Chairperson of the Medicare Choices Commission es-

tablished under section 1860E–51 shall serve as the Secretary of such Board.''.

(c) SUBSIDIES.—Part E of title XVIII of the Social Security Act, as added by section 101 and amended by sections 103 and 105, is further amended by adding at the end the following:

''Subpart 4—Subsidies

''SEC. 1860E–41. CHANGES IN SUBSIDIES.

''(a) REDUCED GOVERNMENT CONTRIBUTION FOR HIGH-INCOME SENIORS.—

''(1) IN GENERAL.—For purposes of determining the combined monthly base amount under section 1860E–32(c)(2)(B) for an individual, in applying section 1839(i) under such section, the following shall apply:

''(A) 2016.—For 2016, notwithstanding paragraph (6) of such section 1839(i), subject to paragraph (3)—

''(i) the threshold amount otherwise applicable under paragraph (2)(A) of such section for individuals shall be equal to $50,000 (or couples, $100,000); and

''(ii) instead of the sliding scale percentage specified in paragraph (3)(A)(i) of such section (and instead of the amount

which would be applied in the case of a joint return described in paragraph (3)(C)(ii) of such section), the sliding scale percentage shall be determined so that for individuals (or couples) whose modified adjusted gross income is within an income tier specified in the table described in paragraph (2) the sliding scale percentage shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage as specified in such table for such income tier for such individuals (or couples, respectively).

''(B) SUBSEQUENT YEARS.—For each subsequent year, such section 1839(i) shall be applied, as modified by subparagraph (A) and subject to paragraphs (3) and (4), without taking into account paragraph (5) or (6) of such section.

''(2) TABLE.—The table specified in this paragraph is as follows:

''Initial Income Level within Tier for Individual (or Couple)	Final Income Level within Tier for Individual (or Couple)	Initial Premium Percentage	Final Premium Percentage
$50,000 ($100,000)	$85,000 ($150,000)	12 percent	20 percent
$85,001 ($150,001)	$130,000 ($214,000)	20 percent	32 percent
$130,001 ($214,001)	$190,000 ($300,000)	32 percent	50 percent
$190,001 ($300,001)	No Limit	50 percent	50 percent.

''(3) TRANSITION FOR CERTAIN SENIORS.—

''(A) IN GENERAL.—In the case of individuals and couples with an income level that is below the minimum level for which section 1839(i) would otherwise apply (as in effect as of the date of enactment of this section), the premium to be applied shall be the sum of—

''(i) the premium otherwise applicable to individuals whose income is $1 below the applicable threshold amount under subsection (a)(1); and

''(ii) the transition percentage of the amount by which the premium that would otherwise apply (but for this paragraph) under this subsection exceeds the premium described in clause (i).

''(B) TRANSITION PERCENTAGE.—The transition percentage specified in this subparagraph—

''(i) for fiscal year 2016, is 20 percent;

"(ii) for fiscal year 2017, is 40 percent;

"(iii) for fiscal year 2018, is 60 percent;

"(iv) for fiscal year 2019, is 80 percent; and

"(v) for any succeeding fiscal year, is 100 percent.

"(4) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year beginning after such date that the minimum income level for which section 1839(i) applies pursuant to paragraph (1)(A)(i) is not greater than 150 percent of the poverty line, each dollar amount in paragraph (1)(A) or (2) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

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

calendar year preceding the first calendar year beginning after such date.

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

''(b) ENHANCED SUBSIDIES TO LOW-INCOME SENIORS.—

''(1) IN GENERAL.—Beginning with 2016, in lieu of any medical assistance available for medicare cost sharing described in section 1905(p)(3), the following shall apply:

''(A) INDIVIDUALS WITH INCOME BELOW 100 PERCENT OF POVERTY LINE (QUALIFIED MEDICARE BENEFICIARIES) AND FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual described in section 1902(a)(10)(E)(i) or subparagraph (A)(ii) of section 1935(c)(6) (taking into account the application of subparagraph (B) of such section), the individual is entitled under this section to an income-related premium subsidy equal to 100 percent of the modified monthly basic beneficiary premium under section 1860E–31(c)(2)

for the MA–PD plan with the lowest bid under the tier 3 benefit level under section 1860E–24(a)(3).

''(B) INDIVIDUALS WITH INCOME BETWEEN 100 PERCENT AND 120 PERCENT OF POVERTY LINE (SPECIFIED LOW-INCOME BENEFICIARIES).—In the case of an individual described in section 1902(a)(10)(E)(iii), the individual is entitled under this section to an income-related premium subsidy equal to 100 percent of the modified monthly basic beneficiary premium under section 1860E–31(c)(2) for the MA–PD plan with the lowest bid under the tier 2 benefit level under section 1860E–24(b).

''(C) OTHER INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE (QUALIFYING INDIVIDUALS).—In the case of an individual described in section 1902(a)(10)(E)(iv), the individual is entitled under this section to an income-related premium subsidy equal to 100 percent of the modified monthly basic beneficiary premium under section 1860E–31(c)(2) for the MA–PD plan with the lowest bid under the tier 1 benefit level under section 1860E–24(b). In no case shall an individual described

in this subparagraph be subject to a late enrollment penalty, which would otherwise be applied under section 1860E–32(c).

''(2) FLEXIBILITY IN USE OF SUBSIDIES.—An individual entitled to an amount of an income-related premium subsidy under paragraph (1) may use the amount of such subsidy toward the premium applied under Medicare fee-for-service or any MA–PD plan offered under any tier benefit level.

''(3) DEPOSIT OF EXCESS INTO HEALTH IRAS.—In the case of such an individual who is an account holder (as defined in section 201(2) of the Save and Strengthen Medicare Act of 2012) and for whom the subsidy amount under this subsection exceeds the premium amount which is applicable to the individual, the Medicare Choices Commission shall provide for the deposit of such excess amount into the health individual retirement account (as defined in section 201(1) of such Act) of such account holder.''.

(d) APPLICATION OF REVISED INCOME THRESHOLDS TO PART D.—Section 1860D–13(a)(7) of the Social Security Act (42 U.S.C. 1395w–113(a)(7)) is amended—

(1) in subparagraph (A), by inserting ''(or, for a calendar year after 2015, the threshold amount

applicable under paragraph (1) of section 1860E–41(a) (including application of paragraph (4) of such section) for the calendar year)'' after ''for the calendar year'';

(2) in subparagraph (B)—

(A) in the matter preceding clause (i), by striking ''The monthly'' and inserting ''Subject to subparagraph (H), the monthly''; and

(B) in clause (i)(I), by inserting ''(or, for a calendar year after 2015, the applicable percentage that would be determined under paragraph (2) of section 1860E–41(a) (including application of paragraph (4) of such section) for the individual for the calendar year if the table specified in subparagraph (G) were substituted for the table specified in the table under such paragraph (2))'' after ''for the calendar year'';

(3) in subparagraph (E)(ii)—

(A) in subclause (I), by inserting ''or, for a year after 2015, the modified adjusted gross income threshold amount applicable under paragraph (1) of section 1860E–41(a) (including application of paragraph (4) of such section)'' before the period at the end; and

(B) in subclause (II), by inserting ''or, for a year after 2015, the applicable percentage that would be determined under paragraph (2) of section 1860E–41(a) (including application of paragraph (4) of such section) if the table specified in subparagraph (G) were substituted for the table specified in the table under such paragraph (2))'' before the period at the end; and

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

''(G) TABLE.—For purposes of subparagraph (B)(i)(I), the table specified in this subparagraph is as follows:

''Initial Income Level within Tier for Individual (or Couple)	Final Income Level within Tier for Individual (or Couple)	Initial Premium Percentage	Final Premium Percentage
$50,000 ($100,000)	$85,000 ($150,000)	25 percent	35 percent
$85,001 ($150,001)	$130,000 ($214,000)	35 percent	50 percent
$130,001 ($214,001)	$190,000 ($300,000)	50 percent	80 percent
$190,001 ($300,001)	No Limit	80 percent	80 percent.

''(H) TRANSITION FOR CERTAIN SENIORS.—In the case of individuals and couples with an income level that is below the minimum level for which section 1839(i) (as in effect as of the date of enactment of this subparagraph) would otherwise apply before application of the amendments made by section 106(b) of the

Save and Strengthen Medicare Act of 2012, the monthly adjustment amount to be applied under subparagraph (B) for such an individual for a month in a fiscal year shall be the transition percentage specified in section 1860E–41(a)(3)(B) for such fiscal year of the monthly adjustment amount otherwise specified under such subparagraph.''.

SEC. 107. MEDICARE CHOICES COMMISSION; GENERAL PROVISIONS; EFFECTIVE DATE.

Part E of title XVIII of the Social Security Act, as inserted by section 101(a)(2) and as previously amended, is further amended by adding at the end the following new subpart:

''Subpart 5—Medicare Choices Commission

''SEC. 1860E–51. MEDICARE CHOICES COMMISSION.

''(a) ESTABLISHMENT.—Subject to subsection (d), there is established as an independent agency of the United States a Medicare Commission (in this part referred to as the 'Medicare Choices Commission').

''(b) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Medicare Choices Commission shall be composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

''(2) DEADLINE FOR INITIAL APPOINTMENT.—The initial members of the Commission shall be nominated for appointment by not later than 6 months after the date of enactment of this title.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 7 years, except that of the members first appointed—

''(i) 3 shall be appointed for terms of 3 years;

''(ii) 2 shall be appointed for terms of 5 years; and

''(iii) 2 shall be appointed for terms of 7 years.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office.

''(C) LIMITATION ON NUMBER OF TERMS.—Any person appointed as a member of the Commission shall not be eligible for re-

appointment to the Commission after having served 2 terms.

''(4) CHAIRPERSON AND OTHER OFFICERS.—The Commission shall elect a chairperson and such officers as the Commission determines appropriate.

''(c) OPERATION OF THE BOARD.—

''(1) MEETINGS.—The Commission shall meet at the call of its chairperson or a majority of its members.

''(2) QUORUM.—A quorum shall consist of 4 members of the Commission, except that the Commission may establish a lesser quorum to conduct a hearing under section 2243(a).

''(d) ASSURING TIMELY IMPLEMENTATION OF COMMISSION.—If, by not later than one year after the date of the enactment of this subpart, the Senate has not consented to a quorum of initial members of the Commission under subsection (b), the duties and powers of the Commission under this part shall be carried out by the Office of the Actuary of the Centers for Medicare & Medicaid Services.

''SEC. 1860E–52. DUTIES OF THE COMMISSION.

''(a) IN GENERAL.—Except as otherwise provided in this title and effective with respect to benefits furnished

on or after January 1, 2015, the Medicare Choices Commission shall—

''(1) coordinate determinations of beneficiary eligibility and enrollment under title XVIII with the Administrator of Social Security;

''(2) oversee and administer the competitive bidding under subpart 3;

''(3) oversee and administer the provisions of part C;

''(4) oversee and administer the provisions of part D;

''(5) distribute funds in appropriate part from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841;

''(6) oversee and enforce the provisions of section 1851(g) (relating to guaranteed issue and renewal), as applied through this part, including to ensure a Medicare Advantage organization offering an MA–PD plan does not impose under such plan an exclusion of benefits based on a pre-existing condition;

''(7) disseminate to Medicare enrollees information with respect to benefits and limitations on payment under Medicare fee-for-service and Medicare

Advantage plans, including a comparative analysis of Medicare plans and the quality of such plans in the area in which the Medicare beneficiary resides;

''(8) establish a Medicare enrollee education program to provide timely, readable, accurate, and understandable information to Medicare enrollees regarding Medicare fee-for-service and Medicare Advantage plan options;

''(9) coordinate and maintain the Medicare.gov Internet Web site; and

''(10) conduct public outreach and education efforts in accordance with section 301 of the Save and Strengthen Medicare Act of 2012.

''(b) RELATION TO MEDICARE FEE-FOR-SERVICE.—The Commission shall not be responsible for the operation of Medicare fee-for-service, but shall have oversight authority over Medicare fee-for-service in a similar manner to that provided with respect to Medicare Advantage plans.

''(c) TRANSITION PROVISIONS.—The Secretary and the Commission shall cooperate to establish an appropriate transition of responsibility for the administration of title XVIII and other related laws, from the Secretary to the Commission as is appropriate to carry out the purposes of this part and as is consistent with the duties of

the Commission described in subsection (a). Insofar as a responsibility is transferred to the Commission under this subsection, any reference to the Secretary or the Centers of Medicare & Medicaid Services in title XVIII or other provision of law with respect to such responsibility is deemed to be a reference to the Commission.

"SEC. 1860E–53. POWERS OF COMMISSION.

''(a) IN GENERAL.—The Medicare Choices Commission may, for the purpose of carrying out its duties, promulgate regulations, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate.

''(b) CONTRACT AUTHORITY.—The Commission may contract with, and compensate, government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(c) COMMISSION AUTHORITY TO PERMIT FLEXIBILITY IN REQUIREMENTS.—In promulgating regulations under subsection (a) to carry out the requirements of part C of title XVIII, the Commission may modify the regulations previously promulgated by the Secretary to carry out such requirements (other than those relating to benefits or beneficiary protections) as may be appropriate to better meet the needs of Medicare enrollees and promote fair and

open competition among Medicare fee-for-service and Medicare Advantage plans.

''(d) OVERSEEING SOLVENCY OF MEDICARE FEE-FOR-SERVICE.—The Commission shall monitor and oversee the financial solvency of Medicare fee-for-service in a manner similar to the manner in which State insurance commissioners monitor and oversee the solvency of health insurance issuers in the States. The Commission shall include in its periodic reports to Congress an analysis of the solvency of Medicare fee-for-service.

''SEC. 1860E–54. COMMISSION PERSONNEL MATTERS.

''(a) MEMBERS.—

''(1) COMPENSATION.—Members of the Medicare Choices Commission shall devote their entire time to the business of the Commission, and each member shall be compensated at a rate equal to the per diem equivalent of the rate provided for level II of the Executive Schedule under section 5315 of title 5, United States Code.

''(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while

away from their homes or regular places of business in the performance of service for the Commission.

''(3) REMOVAL.—The President may remove a member of the Commission only for neglect of duty or malfeasance in office.

''(b) STAFF AND SUPPORT SERVICES.—

''(1) EXECUTIVE DIRECTOR.—The chairperson shall appoint an executive director of the Commission who shall be paid at a rate specified by the Commission.

''(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

''(3) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director

may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(c) TRANSFER OF PERSONNEL, ASSETS, ETC.—For purposes of the Commission carrying out its duties, the Secretary and the Commission may provide for the transfer to the Commission of such civil service personnel employed by the Department of Health and Human Services, and such resources and assets of the Department used in carrying out title XVIII, as the Commission requires.

''SEC. 1860E–55. REPORTS; COMMUNICATIONS WITH CONGRESS.

''(a) REPORT ON MEDICARE PROGRAM.—Not less frequently than annually, the Medicare Choices Commission shall submit to Congress such reports describing the Medicare program under title XVIII as the Commission determines appropriate.

''(b) MAINTAINING INDEPENDENCE OF COMMISSION IN COMMUNICATIONS WITH CONGRESS.—The Commission may directly submit to Congress reports, legislative recommendations, testimony, or comments on legislation. No officer or agency of the United States may require the Commission to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports, recommendations, testimony, or comments.

"SEC. 1860E–56. FUNDING OF THE COMMISSION.

''There is authorized to be appropriated to the Medicare Choices Commission (in appropriate part from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841) such sums as are necessary for the Commission to carry out its duties for each fiscal year beginning with fiscal year 2014.

"Subpart 6—General Provisions

"SEC. 1860E–61. APPLICABILITY; DEFINITIONS.

''(a) IN GENERAL.—The provisions of this Act are superseded to the extent inconsistent with the provisions of this part.

''(b) TERMINOLOGY.—For purposes of this part:

''(1) MEDICARE ENROLLEE.—

''(A) IN GENERAL.—The term 'Medicare enrollee' means—

''(i) an individual entitled to (or enrolled for benefits) under part A and enrolled under part B; and

''(ii) except as otherwise specified, an individual described in section 1860E–11(a)(3).

''(B) TREATMENT.—Any reference in this Act (or any other Act) in effect before the date of the enactment of this part, to an individual

entitled to benefits under part A or enrolled under part B shall be deemed a reference to a Medicare enrollee.

''(2) MEDICARE FEE-FOR-SERVICE.—The term 'Medicare fee-for-service' means the original Medicare fee-for-service program under parts A and B, as modified by this part, and does not include part C or part D.

''(3) MEDICARE FEE-FOR-SERVICE ENROLLEE.—The term 'Medicare fee-for-service enrollee' means a Medicare enrollee who is not enrolled under a Medicare Advantage plan under part C.

''SEC. 1860E–62. GENERAL EFFECTIVE DATE.

''Except as otherwise specified, the provisions of this part shall apply to items and services furnished on or after January 1, 2016, and to plan years beginning on or after such date (referred to in this title as the 'general effective date').''.

TITLE II—HEALTH INDIVIDUAL RETIREMENT ACCOUNTS

Subtitle A—Establishment of Accounts

SEC. 201. DEFINITIONS.

For purposes of this subtitle—

(1) HEALTH INDIVIDUAL RETIREMENT ACCOUNT.—The term ''health individual retirement account'' means an account established under section 203.

(2) ACCOUNT HOLDER.—The term ''account holder'' means any individual for whom an account is established under section 203.

(3) HIRA FUND.—The term ''HIRA Fund'' means the Health Individual Retirement Account Fund established under section 202.

SEC. 202. HEALTH INDIVIDUAL RETIREMENT ACCOUNT FUND.

(a) ESTABLISHMENT OF FUND.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States a trust fund to be known as the Health Individual Retirement Account Fund.

(2) AMOUNTS IN FUND.—The HIRA Fund shall consist of all amounts contributed to the HIRA Fund under section 204, increased by the total net earnings from investments of sums in the HIRA Fund attributable to such contributed amounts, and reduced by the total net losses from investments of such sums.

(3) TRUSTEES.—The Commissioner of Social Security shall serve as trustee of the HIRA Fund.

(4) BUDGET AUTHORITY; APPROPRIATION.—This subtitle constitutes budget authority in advance of appropriations Acts and represents the obligation of the Commissioner to provide for the payment of amounts provided under this subtitle. The amounts held in the HIRA Fund are appropriated and shall remain available without fiscal year limitation.

(b) AVAILABILITY.—The sums in the HIRA Fund are appropriated and shall remain available without fiscal year limitation—

(1) to invest funds in the HIRA Fund under section 205;

(2) to make distributions in accordance with section 206; and

(3) to pay the administrative expenses of the Board in accordance with subsection (d).

(c) LIMITATIONS ON USE OF FUNDS.—

(1) IN GENERAL.—Sums in the HIRA Fund credited to a account holder's health individual retirement account under section 205(a)(1)(2) may not be used for, or diverted to, purposes other than for the exclusive benefit of the account holder or the account holder's beneficiaries under this subtitle.

(2) ASSIGNMENTS.—Sums in the HIRA Fund may not be assigned or alienated and are not subject to execution, levy, attachment, garnishment, or other legal process.

(d) PAYMENT OF ADMINISTRATIVE EXPENSES.—Administrative expenses incurred to carry out this subtitle shall be paid out of net earnings in the HIRA Fund in conjunction with the allocation of investment earnings and losses under section 203(d).

(e) LIMITATION.—The sums in the HIRA Fund shall not be appropriated for any purpose other than the purposes specified in this part and may not be used for any other purpose.

SEC. 203. ESTABLISHMENT OF HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.

(a) ESTABLISHMENT OF PUBLICLY ADMINISTERED SYSTEM OF HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—The Commissioner shall establish a health individual account for each individual who—

(1) receives wages in any calendar year after December 31, 2015, subject to the contribution requirement of section 3101(a) of the Internal Revenue Code of 1986;

(2) derives self-employment income for a taxable year beginning after December 31, 2015, sub-

ject to the contribution requirement of section 1401(a) of such Code; or

(3) is a Medicare enrollee (as defined in section 1860E–61(b) of the Social Security Act).

(b) MANAGEMENT OF ACCOUNTS.—Such account shall be the means by which amounts contributed to, and held in, the HIRA Fund under section 204 are credited to the account holder, under procedures which shall be established by the Commissioner by regulation. Each account shall be identified to the account holder by means of the account holder's social security account number. The Commissioner shall take such steps as are necessary to protect account holders' social security numbers, including not using complete social security numbers on any statements or identification or payment cards.

(c) ACCOUNT BALANCE.—The balance in an account holder's account at any time is the excess of—

(1) all deposits in the HIRA Fund credited to such account holder's health individual retirement account, subject to such increases and reductions as may result from allocations made to and reductions made in the account pursuant to subsection (d); over

(2) amounts paid out of the HIRA Fund in connection with amounts credited to such account holder's account.

(d) ALLOCATION OF EARNINGS AND LOSSES.—Pursuant to regulations which shall be prescribed by the Commissioner, the Commissioner shall allocate to each health individual retirement account an amount equal to the net earnings and net losses from each investment of sums in the HIRA Fund which are attributable to sums credited to such account reduced by an appropriate share of the administrative expenses paid out of the net earnings, as determined by the Commissioner.

SEC. 204. TRANSFER OF HIRA CONTRIBUTIONS TO HIRA FUND.

(a) IN GENERAL.—There is hereby appropriated to the HIRA Fund, out of moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of amounts contributed under sections 3101(d) and 1401(d) of the Internal Revenue Code of 1986. The Secretary of the Treasury shall from time to time transfer such amounts from the general fund in the Treasury to the HIRA Fund.

(b) CONTRIBUTIONS FROM HHS.—The Commissioner shall accept any contributions with respect to an account holder's account, including contributions from the Secretary of Health and Human Services under sections 1860E–25 and 1860E–41(b)(3) of the Social Security Act

and any contribution from a State under section 1944(b) of such Act.

(c) COORDINATION WITH SOCIAL SECURITY TRUST FUNDS.—The amounts contributed under sections 3101(d) and 1401(d) of such Code shall not be taken into account in determining the amounts appropriated and transferred under section 201 of the Social Security Act.

SEC. 205. OPERATION OF HIRA FUND.

(a) SEPARATE CREDITING TO HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—

(1) IN GENERAL.—Subject to this subsection, the Commissioner shall provide for prompt, separate crediting of the amounts deposited in the HIRA Fund to each account holder's health individual savings account to the extent such amount consists of contributions made to the HIRA Fund under section 204 with respect to such account holder, together with any increases or decreases therein so as to reflect the net returns and losses from investment thereof while held in the Fund.

(2) USE OF FUNDS.—The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

(A) to be held for investment under subsection (b), and

(B) to pay the administrative expenses related to the HIRA Fund.

(b) INVESTMENT GUIDELINES.—

(1) IN GENERAL.—For purposes of investment of amounts credited to each health individual retirement account, the Commissioner shall provide by regulation for investment options similar to investment options available under the Thrift Savings Fund under section 8438 of title 5, United States Code.

(2) ELECTIONS AMONG INVESTMENT OPTIONS.—Pursuant to any individual's election filed in accordance with regulations of the Commissioner, the Commissioner shall, in accordance with such regulations, provide for disinvestment and reinvestment of amounts credited to the account holder's health individual retirement account and held in the HIRA Fund under any of the investment options described in paragraph (1).

(3) SPECIAL RULE FOR INVESTING CERTAIN AMOUNTS CONTRIBUTED FROM HHS.—Amounts contributed to any account by the Secretary of Health and Human Services under section 1860E–25 of the Social Security Act may be invested only in the investment option established under paragraph (1)

that is the equivalent to the Government Securities Investment Fund (as defined under section 8438(a)(4) of title 5, United States Code).

(c) ANNUAL DESCRIPTION OF INVESTMENT OPTIONS AND DISCLOSURE OF ADMINISTRATIVE COSTS.—The Commissioner shall provide annually to each account holder—

(1) a description of the investment options available with respect to amounts held in the HIRA Fund and the procedures for selecting such options; and

(2) a disclosure of the rate of administrative costs chargeable with respect to each investment option.

Descriptions and disclosures required under this subsection shall be written in a manner calculated to be understood by the average account holder.

(d) ACCOUNT INFORMATION.—The Commissioner shall create an online portal that enables account holders to view their account information, modify investment allocations, and request quarterly paper account statements.

(e) TREATMENT OF AMOUNTS HELD IN HIRA FUND.—Subject to this subtitle and to the extent provided in section 1860E–25(c)(2) of the Social Security Act with respect to amounts contributed under such section,

amounts deposited into, and held and accounted for in, the HIRA Fund with respect to any account holder shall be treated as property of such account holder, held in trust for such account holder in the Fund.

SEC. 206. HEALTH INDIVIDUAL RETIREMENT ACCOUNT DISTRIBUTIONS.

(a) IN GENERAL.—The Commissioner may distribute amounts from an account holder's health individual retirement account only—

(1) for qualified medical expenses (as defined in section 530A(d)(1) of the Internal Revenue Code of 1986);

(2) to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) of such Code;

(3) by a transfer at the death of the account holder as provided under subsection (b); or

(4) as provided in section 1860E–25(c)(2) of the Social Security Act.

(b) SPECIAL ACCOUNTING RULE FOR CERTAIN AMOUNTS.—Each calendar year, any distributions from an account shall be treated as—

(1) first from any amounts contributed to the account for such calendar year by the Secretary of

Health and Human Services under section 1860E–25 of the Social Security Act, and

(2) then from all other amounts credited to the account.

(c) TREATMENT AT DEATH.—If the account holder dies before all amounts which are held in the HIRA Fund which are credited to the health individual retirement account of the individual are otherwise distributed in accordance with this section, such amounts shall be distributed, under regulations which shall be prescribed by the Commissioner—

(1) in any case in which one or more beneficiaries have been designated in advance, to such beneficiaries in accordance with such designation as provided in such regulations; and

(2) in the case of any amount not distributed as described in paragraph (1), to such individual's estate.

Subtitle B—Tax Treatment

SEC. 211. TAX TREATMENT OF ACCOUNTS.

(a) IN GENERAL.—Subchapter F of chapter 1 of the Internal Revenue Code of 1986 (relating to exempt organizations) is amended by adding at the end the following new part:

"PART IX—HEALTH INDIVIDUAL RETIREMENT ACCOUNT PROGRAM

"SEC. 530A. HEALTH INDIVIDUAL RETIREMENT ACCOUNT PROGRAM.

''(a) TAX TREATMENT OF ACCOUNTS.—The Health Individual Retirement Account Fund is exempt from taxation under this subtitle.

''(b) TREATMENT OF DISTRIBUTIONS.—

''(1) EXCLUSION OF AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health individual retirement account which is used exclusively to pay qualified medical expenses of the account beneficiary shall not be includible in gross income.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health individual retirement account which is used other than as described in paragraph (1) shall be included in the gross income of the account beneficiary.

''(3) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account

of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

''(4) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health individual retirement account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(5) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a health individual retirement account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health individual retirement account with respect to which such spouse is the account beneficiary.

''(6) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

''(A) IN GENERAL.—The transfer of an account beneficiary's interest in a health individual retirement account to another individual

by reason of being the designated beneficiary of such account at the death of the account beneficiary shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this title.

''(B) OTHER CASES.—In the case of any other transfer or acquisition of account beneficiary's interest at the death of the account beneficiary, an amount equal to the fair market value of the assets in such account as of the date of death shall be includible in such beneficiary's gross income for the last taxable year of such beneficiary.

''(c) ESTATE TAX TREATMENT.—No amount shall be includible in the gross estate of any individual for purposes of chapter 11 by reason of an interest in a health individual retirement account of the individual.

''(d) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' means, with respect to an account beneficiary, amounts paid for medical care (as defined in section 213(d)) for such individual, the individual's spouse, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B)

thereof) of the individual, but only to the extent such amounts are not compensated for by insurance or otherwise and only if the individual, spouse, or dependent with respect to whom the amount is paid is entitled, at the time the amount is paid, to a monthly benefit under title II of the Social Security Act or a tier 1 railroad retirement benefit.

''(2) ABORTION AND EUTHANASIA EXCLUDED.—

''(A) IN GENERAL.—Such term shall not include any amount paid for an abortion or for the purposeful causing of, or the purposeful assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply to—

''(i) an abortion—

''(I) in the case of a pregnancy that is the result of an act of rape or incest, or

''(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician,

place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy, and

''(ii) the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion.

''(3) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the account holder (as defined in section 201 of the Save and Strengthen Medicare Act of 2012) on whose behalf the health individual retirement account is held.

''(4) HEALTH INDIVIDUAL RETIREMENT ACCOUNT.—The term 'health individual retirement account' means an account established under section 203(b) of the Save and Strengthen Medicare Act of 2012.

''(5) HEALTH INDIVIDUAL RETIREMENT ACCOUNT FUND.—The term 'Health Individual Retirement Account Fund' means the Fund established under section 202 of the Save and Strengthen Medicare Act of 2012.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter F of chapter 1 of such Code is amended by adding at the end the following new item:

"PART IX. HEALTH INDIVIDUAL RETIREMENT ACCOUNT PROGRAM".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2015.

SEC. 212. HIRA CONTRIBUTIONS.

(a) EMPLOYMENT.—

(1) IN GENERAL.—Section 3101 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(d) HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—

"(1) IN GENERAL.—In addition to the taxes imposed by subsections (a) and (b), there shall be deducted and withheld from the income of every individual an amount equal to the applicable percentage of wages (as defined in section 3121(a)) received by him with respect to employment during any taxable year.

"(2) LIMITATION.—The amount deducted and withheld under paragraph (1) shall not exceed $2,500 ($5,000 in the case of a married couple filing jointly) for any taxable year.

''(3) APPLICABLE PERCENTAGE.—For purposes of this subsection, the applicable percentage shall be 2 percent, or such other percentage (including zero) as the individual elects in such form and manner as the Secretary shall prescribe.

''(4) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any taxable year beginning after 2016, the dollar amounts under the third sentence of subsection (a) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting '2015' for '1992' in subparagraph (B) thereof.

''(B) ROUNDING.—If any amount as adjusted under subparagraph (A) is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.''.

(2) CONTRIBUTIONS PRE-TAX.—Subsection (a) of section 3401 of such Code is amended by adding at the end the following new sentence: ''Such term shall not include so much of any amounts deducted and withheld from such remuneration under section

3101(d) for any taxable year as does not exceed $2,500 ($5,000 in the case of a married couple filing jointly).''.

(b) SELF-EMPLOYMENT.—

(1) IN GENERAL.—Section 1401 of such Code is amended by adding at the end the following new subsection:

''(d) HEALTH INDIVIDUAL RETIREMENT ACCOUNTS.—

''(1) IN GENERAL.—In addition to the taxes imposed by the preceding subsections, in the case of an individual with self-employment income for the taxable year, such individual shall contribute for such taxable year an amount equal to the applicable percentage of such self employment income.

''(2) APPLICABLE PERCENTAGE.—For purposes of this subsection, the applicable percentage shall be 2 percent, or such other percentage (including zero) as the individual elects, in such form and manner as the Secretary shall prescribe.

''(3) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any taxable year beginning after 2016, the dollar amounts under subsection (a)(18) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting '2015' for '1992' in subparagraph (B) thereof.

"(B) ROUNDING.—If any amount as adjusted under subparagraph (A) is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.".

(2) DEDUCTION FOR SELF-EMPLOYMENT AMOUNTS CONTRIBUTED TO HIRA.—Subsection (a) of section 1401 of such Code is amended by striking "and" at the end of paragraph (16), but striking the period at the end of paragraph (17) and inserting "; and", and by inserting after paragraph (17) the following new paragraph:

"(18) there shall be excluded so much of any amounts contributed by the individual for such taxable year under 1401(d) as does not exceed $2,500 ($5,000 in the case of a married couple filing jointly) reduced (but not below zero) by the amount of contributions for the taxable year with respect to the individual under section 3101.".

(c) PROCEDURE FOR RECONCILIATION.—The Secretary of the Treasury shall, in consultation with the Commission of Social Security, prescribe such regulations and guidance as are necessary to—

(1) allow the taxpayer to make additional contributions in any case in which contributions for the taxable year are less than the applicable limitations for the taxable year under sections 3101(d) and 1401(d) with respect to the taxpayer, and

(2) provide for adding to gross income of the taxpayer for the taxable year amounts equal to any contributions in excess of such applicable limitations.

(d) ELECTION COORDINATION.—The Secretary of the Treasury and the Commissioner of Social Security shall consult and cooperate in prescribing the time, form, and manner of elections under sections 3101(d) and 1401(d) of the Internal Revenue Code of 1986 and section 203(a) this Act so as to reduce unnecessary paperwork and duplication.

SEC. 213. CONTRIBUTIONS ELIGIBLE FOR SAVER'S CREDIT.

(a) IN GENERAL.—Paragraph (1) of section 25B(d) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting

‘‘, and’’, and by adding at the end the following new subparagraph:

‘‘(D) the amount of contributions with respect to the individual pursuant to sections 3101(d) and 1401(d) (reduced or increased, as the case may be, to account for any reconciliation under section 212(d) of the Save and Strengthen Medicare Act of 2012).’’.

(b) PORTION OF CREDIT MADE REFUNDABLE.—Section 25B of such Code is amended by adding at the end the following new subsection:

‘‘(h) PORTION OF CREDIT REFUNDABLE.—

‘‘(1) IN GENERAL.—The aggregate credits allowed to a taxpayer under subpart C shall be increased by the lesser of—

‘‘(A) the credit which would be allowed under this section without regard to this subsection and the limitation under section 26(a)(2) or subsection (g), as the case may be, or

‘‘(B) the amount by which the aggregate amount of credits allowed by this subpart (determined without regard to this subsection) would be increased if the limitation imposed by section 26(a)(2) or subsection (g), as the case

may be, were increased by an amount equal to the taxpayer's hospital insurance taxes for the taxable year.

The amount of the credit allowed under this subsection shall not be treated as a credit allowed under this subpart and shall reduce the amount of credit otherwise allowable under subsection (a) without regard to section 26(a)(2) or subsection (g), as the case may be.

''(2) HOSPITAL INSURANCE TAX.—

''(A) IN GENERAL.—The term 'hospital insurance taxes' means, with respect to any taxpayer for any taxable year—

''(i) the amount of the taxes imposed by sections 3101(b) and 3201(a) (to the extent attributable to the rate in effect under section 3101(b)) on amounts received by the taxpayer during the calendar year in which the taxable year begins,

''(ii) the amount of the taxes imposed by sections 3111(b) and 3221(a) (to the extent attributable to the rate in effect under section 3111(b)) on amounts paid by the employer to the taxpayer with respect

to employment during the calendar year in which the taxable year begins,

"(iii) the amount of the taxes imposed by section 1401(b) on the self-employment income of the taxpayer for the taxable year, and

"(iv) the amount of the taxes imposed by section 3211(a) (to the extent attributable to the rate in effect under sections 3101(b) and 3111(b)) on amounts received by the taxpayer during the calendar year in which the taxable year begins.

"(B) COORDINATION WITH SPECIAL REFUND OF TAX.—The term 'hospital insurance taxes' shall not include any taxes to the extent the taxpayer is entitled to a special refund of such taxes under section 6413(c).

"(C) SPECIAL RULE.—Any amounts paid pursuant to an agreement under section 3121(l) (relating to agreements entered into by American employers with respect to foreign affiliates) which are equivalent to the taxes referred to in subparagraph (A)(i) shall be treated as taxes referred to in such subparagraph.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2015.

SEC. 214. EXCLUSION OF CERTAIN HIRA TRANSFERS.

(a) IN GENERAL.—Part II of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting before section 140 the following new section:

"SEC. 139F. GOVERNMENT HIRA SUBSIDIES.

''Gross income shall not include any payment to the health individual retirement account (as defined in section 530A(d)(3)) of an individual by the Secretary of Health and Human Services under part E of title XVIII of the Social Security Act.''.

Subtitle C—Other Tax Provisions

SEC. 221. HEALTH SAVINGS ACCOUNTS AVAILABLE TO INDIVIDUALS ELIGIBLE FOR MEDICARE.

(a) IN GENERAL.—Subsection (b) of section 223 of the Internal Revenue Code of 1986 is amended by striking paragraph (7) and by redesignating paragraph (8) as paragraph (7).

(b) ELIMINATION OF MEDICARE ELIGIBILITY EXCEPTION TO NONQUALIFIED WITHDRAWAL PENALTY.—Paragraph (4) of section 223(f) of such Code is amended by striking subparagraph (C).

(c) CONFORMING AMENDMENT.—Subparagraph (S) of section 26(b)(2) of such Code is amended by striking ''223(b)(8)(B)(i)(II)'' and inserting ''223(b)(7)(B)(i)(II)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2015.

SEC. 222. REDUCTION IN MEDICARE PORTION OF PAYROLL TAX TO INCENTIVIZE LATE RETIREMENT.

(a) EMPLOYEES.—Section 3101 of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new subsection:

''(e) EXCEPTION FOR INDIVIDUALS 65 AND OLDER.—

''(1) IN GENERAL.—In the case of an individual who has attained the age of 65, the rate of tax otherwise in effect under subsection (b)—

''(A) shall be ½ such rate, if such individual has not attained the applicable age, and

''(B) shall be zero, if such individual has attainted the applicable age.

''(2) APPLICABLE AGE.—For purposes of this subsection—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable age shall be 67.

"(B) PREFERRED MEDICARE AGE.—In the case of wages received after December 31, 2025, the applicable age shall be the preferred Medicare age (within the meaning of section 216(m)(2)(B) of the Social Security Act).".

(b) EMPLOYERS.—Section 3111 of such Code is amended by adding at the end the following new subsection:

"(d) EXCEPTION FOR INDIVIDUALS 65 AND OLDER.—In the case of an individual who has attained the age of 65, the rate of tax otherwise in effect under subsection (b)—

"(1) shall be ½ such rate, if such individual has not attained the applicable age (within the meaning of section 3101(e)(2)), and

"(2) shall be zero, if such individual has attained such age.".

(c) SELF-EMPLOYMENT.—Section 1401 of such Code, as amended by this Act, is amended by adding at the end the following new subsection:

"(e) EXCEPTION FOR INDIVIDUALS 65 AND OLDER.—

''(1) IN GENERAL.—In the case of an individual who has attained the age of 65, the rate of tax otherwise in effect under subsection (b) for the taxable year—

''(A) shall be ½ such rate, if such individual has not attained the applicable age before the end of such taxable year, and

''(B) shall be zero, if such individual has attained such age before the end of such taxable year.

''(2) APPLICABLE AGE.—For purposes of this subsection—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable age shall be 67.

''(B) PREFERRED MEDICARE AGE.—In the case of taxable years beginning after December 31, 2025, the applicable age shall be the preferred Medicare age (within the meaning of section 216(m)(2)(B) of the Social Security Act).''.

(d) EFFECTIVE DATES.—

(1) SUBSECTIONS (a) AND (b).—The amendments made by subsections (a) and (b) shall apply to wages paid after December 31, 2015.

(2) SUBSECTION (c).—The amendments made by subsection (c) shall apply to remuneration paid in taxable years ending after December 31, 2015.

SEC. 223. 15-PERCENT EXCISE TAX ON EMPLOYER-SPONSORED MEDICARE SUPPLEMENTAL COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 4980J. EMPLOYER-SPONSORED MEDICARE SUPPLEMENTAL COVERAGE.

''(a) IMPOSITION OF TAX.—In the case of any employee who—

''(1) becomes a Medicare enrollee (as defined in section 1860E–61(b) of the Social Security Act) after December 31, 2015, and

''(2) is covered for any period during a calendar year beginning after such date under applicable employer-sponsored supplemental coverage,

there is hereby imposed a tax equal to 15 percent of the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of such coverage of the employee for such period.

''(b) LIABILITY TO PAY TAX.—The coverage provider (as defined in section 4980I(c)(1)) shall pay the tax imposed by subsection (a).

''(c) APPLICABLE EMPLOYER-SPONSORED SUPPLEMENTAL COVERAGE.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable employer-sponsored supplemental coverage' means, with respect to any employee, any first-dollar coverage made available by an employer to an employee during the calendar year.

''(2) FIRST-DOLLAR INSURANCE COVERAGE.—The term 'first-dollar insurance coverage' means coverage for—

''(A) the amount of the unified deductible for the calendar year under section 1860E–21(b) of the Social Security Act, and

''(B) the first $500 of coinsurance for the calendar year under section 1860E–22 of such Act.

''(3) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored supplemental coverage without regard to whether the employer or employee pays for the coverage.

''(4) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

''(5) EMPLOYEE.—The term 'employee' includes any former employee, surviving spouse, or other primary insured adult.

''(6) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian 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 such government.

''(7) NOT APPLICABLE TO CERTAIN ACCOUNTS.—The term 'first-dollar coverage' does not include coverage under a flexible spending arrangement (as defined in section 106(c)(2)), coverage under an arrangement under which the employer makes contributions described in subsection (b) or

(d) of section 106, a health reimbursement arrangement treated as employer coverage under an accident or health plan for purposes of section 106, or coverage under a health individual retirement account (as defined in section 530A(d)(3)).

''(8) DENIAL OF DEDUCTION.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

''(d) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980J. Employer-sponsored Medicare supplemental coverage.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to periods after December 31, 2015.

TITLE III—OTHER HEALTH PROVISIONS

Subtitle A—Transparency, Outreach, and Education

SEC. 301. PUBLIC OUTREACH AND EDUCATION INITIATIVES.

Beginning not later than January 1, 2015, the Medicare Choices Commission shall conduct public outreach

and education efforts, through a variety of media and forums, to provide information to Medicare enrollees (as defined in section 1860E–51 of the Social Security Act), providers of services and suppliers (as such terms are defined in section 1861 of such Act), health insurance plans, and other appropriate individuals and entities on the modifications made by the provisions of, including amendments made by, this Act to Medicare under title XVIII of the Social Security Act. Such efforts shall include at least the following:

(1) Interactive Web sites for Medicare enrollees.

(2) Opportunities for Medicare enrollees to sign up for informational emails from the Centers of Medicare & Medicaid Services.

(3) Social media pages to provide basic facts to Medicare enrollees and family members of such enrollees.

(4) National town hall meetings.

(5) Educational materials for hospitals, medical schools, and other providers of services and suppliers.

(6) Resources for physicians, home nurses, and other medical professionals to provide to patients.

(7) Coordination with a broad range of community partners, including community centers, retire-

ment centers, assisted living communities, and faith-based organizations.

(8) Coordination with health plans.

SEC. 302. ANNUAL MEDICARE BENEFICIARY CONTRIBUTIONS AND BENEFITS STATEMENTS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act is amended by inserting after section 1143 (42 U.S.C. 1320b–13) the following new section:

"SEC. 1143A. ANNUAL MEDICARE BENEFICIARY CONTRIBUTIONS AND BENEFITS STATEMENTS.

''(a) PROVISION.—

''(1) IN GENERAL.—Beginning not later than 2 years after the date of the enactment of this section, the Medicare Choices Commission established under section 1860E–51, in coordination with the Commissioner of Social Security, shall provide a statement described in subsection (b) (in this section referred to as an 'annual Medicare information statement') on an annual basis to each eligible individual (as defined in subsection (d)) for whom a current mailing address can be determined through such methods as the Medicare Choices Commission determines to be appropriate.

''(2) COORDINATION IN SINGLE MAILING WITH SOCIAL SECURITY ACCOUNT STATEMENTS.—In order

to avoid sending separate statements under this section and section 1143 in the case of an individual for whom a social security account statement is provided under section 1143 and a separate annual Medicare information statement would otherwise be provided under this section, the Medicare Choices Commission shall coordinate with the Commissioner of Social Security, whether through transmittal of data or otherwise, in a manner so that the annual Medicare information statement is included and sent with such social security account statement.

''(3) METHODOLOGY.—

''(A) IN GENERAL.—The Medicare Choices Commission, in consultation with the Commissioner of Social Security and the Secretary of the Treasury, shall specify the methodology to be used in estimating lifetime contributions and lifetime benefits with respect to annual Medicare information statements. Such methodology for computing the lifespan of an individual shall be the same methodology used for purposes of the social security account statement under section 1143.

''(B) INCLUSION OF DESCRIPTION IN STATEMENT.—The Medicare Choices Commis-

sion shall include a brief description of the key assumptions used in such methodology in the annual Medicare information statements.

''(4) SUMMARY OF MEDICARE PROGRAM.—Each annual Medicare information statement shall include a summary of the Medicare programs under title XVIII, including a summary description of the status of the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, using information from the most recent report of the Board of Trustees of such Fund. Such summary shall also include a summary description of benefits and enrollment options under parts C and D of such title, but shall indicate that the information described in subsection (b) does not include information related to contributions and benefits under those parts.

''(b) MEDICARE INFORMATION STATEMENT DESCRIBED.—In addition to the information described in paragraphs (3)(B) and (4) of subsection (a), each annual Medicare information statement for an eligible individual shall contain the following:

''(1) HI EMPLOYEE CONTRIBUTIONS.—The total contributions described in section 1143(a)(2)(C) for the individual—

''(A) for the most recent year for which data are available;

''(B) to the extent feasible, for previous periods through the end of such year; and

''(C) as projected for the individual during the individual's lifetime.

To the extent feasible, of such total contributions the portion that is attributable to employer, employee, and self-employment contributions.

''(2) MEDICARE BENEFITS.—In the case of an eligible individual—

''(A) an estimate of the actuarial value of the expected benefits under such parts for the individual during the individual's lifetime, including (but stated separately) any benefits described in subparagraph (A); and

''(B) if, for such most recent year, such individual was a Medicare enrollee (as defined in section 1860E–61(b)), the total value of such benefits provided to the individual under such parts as of the end of such year and, to the extent feasible, the total value of such benefits for

such individual for previous periods through the end of such year.

''(3) COMPARISON.—An appropriate comparison of such contributions with such benefits.

''(c) RECORDS RETENTION.—The Medicare Choices Commission shall provide for the indefinite retention of information that—

''(1) is described in subsection (b), including benefits described in subsection (b)(2); and

''(2) the Medicare Choices Commission has not discarded as of the date of the enactment of this section.

''(d) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term 'eligible individual' means an individual—

''(1) who has a social security account number;

''(2) who has attained age 25 or over; and

''(3) who is a Medicare enrollee (as defined in section 1860E–61(b)) or who, as of the end of the most recent year referred to in subsection (b)(1)(A), has had any contributions described in subsection (b)(1) made with respect to the individual during such year or a previous year.''.

(b) INCLUSION OF SOCIAL SECURITY ACCOUNT STATEMENT FOR THOSE RECEIVING ANNUAL MEDICARE INFORMATION STATEMENT.—Section 1143(a)(3) of such

Act (42 U.S.C. 1320b–13(a)(3)) is amended by adding at the end the following:

''Such term includes an individual not described in the previous sentence who is an eligible individual (as defined in subsection (d) of section 1143A) for whom an annual Medicare information statement is provided under such section.''.

Subtitle B—Miscellaneous

SEC. 311. REPEAL OF IPAB.

Effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), the provisions of, and amendments made by, sections 3403 and 10320 of such Act (other than subsection (d) of section 1899A of the Social Security Act, as added and amended by such sections) are repealed.

SEC. 312. REPEAL OF MEDICARE PAYMENT PRODUCTIVITY ADJUSTMENTS AFTER 2020.

The provisions of, and amendments made by, section 3401 of the Patient Protection and Affordable Care Act (Public Law 111–148), as amended by title X of such Act and section 1105 of the Health Care and Education Reconciliation Act of 2010, insofar as such provisions (and amendments) relate to a productivity adjustment, shall not apply with respect to payments for items or services

furnished during any year after fiscal year 2020 or calendar year 2020, as applicable.

SEC. 313. GRADUATE MEDICAL EDUCATION GRANT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"SEC. 1899B. GRADUATE MEDICAL EDUCATION GRANT PROGRAM.

"(a) ESTABLISHMENT.—For cost reporting periods occurring during fiscal year 2015 or a subsequent fiscal year, the Secretary shall carry out a grant program under which the Secretary shall provide to each hospital with an approved medical residency training program a grant in accordance with the subsequent provisions of this section for costs of such hospital for indirect and direct graduate medical education. Such grants are instead of any payment under subsection (d)(5)(B) or (h) of section 1886, payments for direct or indirect medical education costs under title XIX, or section 340E of the Public Health Service Act for such costs during such fiscal year.

"(b) GRANT AMOUNT.—Subject to subsections (c) and (d), the amount of a grant to a hospital under subsection (a) for a cost reporting period occurring during a fiscal year shall be equal to—

''(1) in the case of a subsection (d) hospital, the sum of—

''(A) the payment amount the hospital would have received under section 1886(h)(3), without application of this section or the last sentence of section 1886(h)(1), for such cost reporting period; and

''(B) 72 percent of the additional payment amount the hospital would have received under section 1886(d)(5)(B), without application of this section or clause (xii) of such section 1886(d)(5)(B), for such cost reporting period;

''(2) in the case of a hospital in a State, an amount determined in accordance with a methodology specified by the Secretary, which shall be in lieu of any amount that the hospital otherwise would, without application of this section or section 1903(i)(27), have received under the State plan under title XIX for expenses of such hospital attributable to the costs of direct and indirect graduate medical education; and

''(3) in the case of a children's hospital (as defined in subsection (g) of section 340E of the Public Health Service Act), the sum of—

"(A) the amount that would be determined under subsection (c) of such section for such hospital for direct expenses associated with operating approved graduate medical residency training programs for such period, without application of this section or subsection (h) of such section 340E; and

"(B) the amount that would be determined under subsection (d) of such section for such hospital for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs for such period, without application of this section or subsection (h) of such section 340E.

"(c) MODIFICATION.—Subject to subsection (d)(1), the Secretary may modify the grant amounts under subsection (b), including after application of subsection (d)(2), based on factors such as the number of residents of approved medical residency training programs, the extent to which such programs provide for primary care training, the curriculum of such programs, and the quality of care provided through such programs.

"(d) LIMITATION.—

''(1) IN GENERAL.—In no case may the aggregate amount of grants awarded under subsection (a) for a fiscal year exceed the amount made available under subsection (e)(1) for such fiscal year for carrying out this section.

''(2) PRO-RATION.—In the case of a fiscal year for which the aggregate amount of grants under this section is projected to exceed the amount made available under subsection (e)(1) for such fiscal year for carrying out this section, the Secretary shall reduce the amount of each grant awarded under this section for such fiscal year by a prorated amount. Subject to paragraph (1), the Secretary may modify such a prorated amount in accordance with subsection (c).

''(e) FUNDING.—

''(1) IN GENERAL.—For fiscal year 2015 and each subsequent fiscal year, amounts in the Graduate Medical Education Trust Fund under section 9512 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Secretary to carry out this section.

''(2) TRANSFERS TO GME TRUST FUND.—There shall be provided for the transfer to the Graduate Medical Education Trust Fund by the Medicare

Choices Commission in appropriate part from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the following:

"(A) For fiscal year 2015, an amount equal to the aggregate amount that would have been calculated under subsection (b)(1) for such fiscal year for all hospitals with approved medical residency training programs if the percentage described in paragraph (1)(B) of such subsection were 82 percent.

"(B) For fiscal year 2016 and each subsequent fiscal year, the amount transferred under this paragraph for the previous fiscal year increased by the annual percentage increase in the medical component of the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

"(f) DEFINITIONS.—The terms 'approved medical residency training program' and 'direct graduate medical education costs' have the meanings given such terms under section 1886(h)(5).".

(b) GME TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9512. GRADUATE MEDICAL EDUCATION TRUST FUND.

"(a) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Graduate Medical Education Trust Fund' (hereafter in this section referred to as the 'GME Trust Fund'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—

"(1) TRUST FUND TRANSFERS.—There shall be credited to the GME Trust Fund for fiscal year 2015 and each subsequent fiscal year—

"(A) the amounts transferred under section 1899B of the Social Security Act; and

"(B) the amounts transferred from the Patient-Centered Outcomes Research Trust Fund under section 9511(g).

"(2) APPROPRIATION.—There are hereby appropriated to the GME Trust Fund for fiscal year 2015 and each subsequent fiscal year an amount equal to the aggregate payment amounts determined

for such fiscal year under section 1899B(b)(2) of the Social Security Act.

''(3) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts credited to the GME Trust Fund under paragraph (1) for a fiscal year, there are authorized to be appropriated to the Trust Fund—

''(A) for each of fiscal years 2015 and 2016, $200,000,000; and

''(B) for each of fiscal years 2017 and 2018, $100,000,000.

''(c) EXPENDITURES FROM FUND.—Amounts in the GME Trust Fund are available, without further appropriation, to the Secretary for carrying out section 1899B of the Social Security Act.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

''Sec. 9512. Graduate Medical Education Trust Fund.''.

(c) CONFORMING AMENDMENTS.—

(1) SUNSET MEDICARE GME.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(A) in subsection (d)(5)(B)—

(i) by redesignating the second clause (x) as clause (xi); and

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

''(xii) For cost reporting periods beginning on or after October 1, 2014, no additional payment amount for subsection (d) hospitals with indirect costs of medical education shall be made under this subparagraph and instead payments for such costs shall be made in accordance with section 1899B.''; and

(B) in subsection (h)(1), by adding at the end the following new sentence: ''For cost reporting periods beginning on or after October 1, 2014, no payments for direct graduate medical education costs shall be made under this subsection and instead payments for such costs shall be made in accordance with section 1899B.''.

(2) SUNSET MEDICAID GME.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(A) in paragraph (25), by striking ''or'' at the end;

(B) in paragraph (26), by striking the period at the end and inserting ''; or''; and

(C) by inserting after paragraph (26) the following new paragraph:

''(27) with respect to any amounts expended on or after October 1, 2014, for payments to hospitals for direct or indirect costs of graduate medical education.''.

(3) SUNSET PHSA CHILDREN'S HOSPITAL GME.—Section 340E of the Public Health Service Act (42 U.S.C. 256e) is amended—

(A) in the first sentence of subsection (a), by striking ''The Secretary'' and inserting ''Subject to subsection (h), the Secretary''; and

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

''(h) SUNSET.—For fiscal year 2015 and each subsequent fiscal year, no payments shall be made under this section to a children's hospital for the direct expenses and the indirect expenses associated with operating approved graduate medical residency training programs and instead payments for such expenses shall be made to such hospital in accordance with section 1899B of the Social Security Act.''.

(4) TRANSFER OF PCORI FUNDS.—

(A) MEDICARE TRANSFER.—Section 1183 of the Social Security Act is amended—

(i) in the heading, by striking ''**PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND**'' and inserting ''**GRADUATE MEDICAL EDUCATION TRUST FUND**''; and

(ii) in subsection (a), by striking ''to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986'' and inserting ''to the Graduate Medical Education Trust Fund under section 9512 of the Internal Revenue Code of 1986''.

(B) PCORI TRUST FUND.—Section 9511 of the Internal Revenue Code of 1986 is amended—

(i) in subsection (d)(1), by inserting ''and subsection (g)'' after ''paragraph (2)''; and

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

''(g) TRANSFER TO GRADUATE MEDICAL EDUCATION TRUST FUND.—The Secretary of the Treasury shall

transfer to the Graduate Medical Education Trust Fund under section 9512 all funds made available, appropriated, or transferred to the trust fund under this section on or after October 1, 2014.''.

SEC. 314. REPORT ON TRANSITIONING PAYMENTS UNDER MEDICARE FOR DISPROPORTIONATE SHARE HOSPITALS INTO A GRANT PROGRAM.

Not later than December 31, 2017, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations on the extent to which—

(1) adjustments in payments under section 1886(d)(5)(F) of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals should be terminated; and

(2) instead of such adjustments described in paragraph (1) there should be established a grant program (separate from the Medicare programs under title XVIII of the Social Security Act) to provide disproportionate care hospitals funding for providing such services.

SEC. 315. ONE-YEAR FREEZE FOR PHYSICIAN PAYMENT UPDATE; SENSE OF CONGRESS RELATING TO THE SUSTAINABLE GROWTH RATE (SGR).

(a) ONE-YEAR FREEZE FOR PHYSICIAN PAYMENT UPDATE.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(14) UPDATE FOR 2013.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor shall be zero percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.''.

(b) SENSE OF CONGRESS RELATING TO THE SUSTAINABLE GROWTH RATE (SGR).—It is the Sense of Congress that the sustainable growth rate (SGR) formula under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4(d)

is fundamentally flawed and that replacing such formula with a payment system that protects the access of seniors to high-quality physician care should be an urgent priority.

SEC. 316. IMPROVEMENTS TO MSA PLANS; PERMITTING OFFERING OF CATASTROPHIC PLAN WITH HIGH DEDUCTIBLE AND CONTRIBUTION TO MSA, HSA, OR HIRA.

(a) MSA PLAN MAY CHOOSE TO NOT APPLY DEDUCTIBLE TO PREVENTIVE SERVICES.—Section 1859(b)(3) of the Social Security Act is amended—

(1) in subparagraph (A), by inserting ", subject to subparagraph (C)" after "plan that"; and

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

"(C) DEDUCTIBLE NOT APPLICABLE TO PREVENTIVE SERVICES.—With respect to expenses incurred during the first plan year beginning on or after the date of the enactment of this subparagraph or a subsequent plan year, a Medicare Advantage organization offering an MSA plan may waive application of the deductible under this paragraph with respect to preventive care (within the meaning of section 1871) under such plan and such waiver shall

not affect the plan satisfying the definition under subparagraph (A).''.

(b) MA AND MSA PLANS ALLOWED TO MAKE MEDICARE ADVANTAGE MSA CONTRIBUTIONS.—Section 138(b)(2) of the Internal Revenue Code of 1986 is amended—

(1) in subparagraph (A), by striking at the end ''or'';

(2) in subparagraph (B), by adding at the end ''or''; and

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

''(C) a contribution made by a Medicare Advantage plan or MSA plan under part C of title XVIII of the Social Security Act pursuant to subparagraph (B) or (D) of section 1851(a)(2) of such Act,''.

(c) MA PLANS OFFERED MAY INCLUDE CATASTROPHIC PLAN WITH HIGH DEDUCTIBLE AND MSA, HSA, OR HIRA CONTRIBUTION.—Section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) COMBINATION CATASTROPHIC HIGH DEDUCTIBLE PLAN WITH MSA, HSA, OR HIRA

CONTRIBUTION.—A plan offering catastrophic coverage with a high deductible feature (as described in section 1882(p)(11)(B)), and a contribution by such plan into a Medicare Advantage medical savings account (MSA) (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), a health savings account (as defined in section 223(d) of the Internal Revenue Code of 1986), or a health individual retirement account established under section 503(b) of the Save and Strengthen Medicare Act of 2012.''.

SEC. 317. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) NO PERIOD LIMITATION APPLIED FOR RESTRICTED ENROLLMENTS.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''and for periods before January 1, 2014''.

(b) PERIOD FOR MEETING APPLICABLE REQUIREMENTS EXTENDED.—Section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)) is amended by striking '', as of January 1, 2010,''.

(c) EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements

for Patients and Providers Act of 2008 (Public Law 110–275), as amended by section 3205(d) of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking ''December 31, 2012'' and inserting ''December 31, 2015''.

SEC. 318. CONSCIENCE PROTECTIONS.

Part F of title XVIII of the Social Security Act, as redesignated by section 101(a)(1) and amended by section 313, is further amended by adding at the end the following new sections:

''SEC. 1899C. CONSCIENCE PROTECTIONS; PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE AND ABORTION SERVICES.

''(a) PROHIBITION ON FUNDING FOR ABORTIONS.—No payment may be made under this title for any expenses incurred for any abortion.

''(b) PROHIBITION ON FUNDING FOR HEALTH BENEFITS PLANS THAT COVER ABORTION.—No payment may be made under this title for any expenses for coverage under an MA plan or prescription drug plan that includes coverage of any abortion.

''(c) TREATMENT OF ABORTIONS RELATED TO RAPE, INCEST, OR PRESERVING THE LIFE OF THE MOTHER.—The limitations established in the previous subsections shall not apply to an abortion—

''(1) if the pregnancy is the result of an act of rape or incest; or

''(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself.

''SEC. 1899D. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE AND ABORTIONS.

''(a) IN GENERAL.—The Federal Government, any MA plan or prescription drug plan that receives payment under this title, and any provider of services or supplier that receives payment under this title with respect to Medicare fee-for-service (as defined in section 1860E–61(b)) may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide—

''(1) any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing; or

''(2) abortions.

''(b) DEFINITION.—In this section, the term 'health care entity' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

''(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES IN THE CASE OF ASSISTED SUICIDE.—Nothing in subsection (a)(1) shall be construed to apply to, or to affect, any limitation relating to—

''(1) the withholding or withdrawing of medical treatment or medical care;

''(2) the withholding or withdrawing of nutrition or hydration; or

''(3) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

''(d) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section. Any such complaint shall, by not later than

180 days after receipt by the Office of such complaint, be reviewed by the Office and, as appropriate, referred to the Medicare Choices Commission or Centers for Medicare & Medicaid Services for purposes of subsection (e).

''(e) ENFORCEMENT.—

''(1) MA PLANS AND PRESCRIPTION DRUG PLANS.—In the case of an MA plan or prescription drug plan that is in violation of subsection (a), the Medicare Choices Commission may, as determined appropriate by the Commission—

''(A) apply against the MA organization offering the MA plan or the PDP sponsor offering the prescription drug plan a civil monetary penalty or assessment in the same manner as such a penalty or assessment is authorized under section 1128A(a);

''(B) exclude the plan from participation under this title, in accordance with the procedures of subsections (c), (f), and (g) of section 1128; or

''(C) apply both subparagraphs (A) and (B) with respect to the plan.

''(2) MEDICARE FEE-FOR-SERVICE PROVIDERS OF SERVICES AND SUPPLIERS.—In the case of a provider of services or supplier described in subsection

(a) that is in violation of such subsection, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, may, as determined appropriate by the Secretary—

''(A) apply against the provider of services or supplier a civil monetary penalty or assessment in the same manner as such a penalty or assessment is authorized under section 1128A(a);

''(B) exclude the provider of services or supplier from participation under this title, in accordance with the procedures of subsections (c), (f), and (g) of section 1128; or

''(C) apply both subparagraphs (A) and (B) with respect to the provider of services or supplier.

''(3) ADMINISTRATION.—The provisions of section 1128A (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under paragraph (1) or (2) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent

such provisions are inconsistent with paragraph (1)(B) or (2)(B), respectively.''.

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