PRELIMINARY DRAFT OF "SUSAN SHRED"

[Hyperlinked, noted & commented]

Sanders – Transition Title
OF HIS 4-10-2019 released

"… Medicare-for-all national health insurance program …"

https://www.congress.gov/bill/116th-congress/senate-bill/1129

NOTE:
TITLEX (of Mr. Sander's BiLL) addS AT LEAST 12 (TWELVE) new - SECTIONS, subparagraphS, clauseS,paragraphS, subclauseS, sentenceS, subsectionS TO EXISTING LEGAL LANGUAGE IN the Social Security Act

(I have highlighted the new or changed language in RED.)

https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm

https://en.wikipedia.org/wiki/Social_Security_Act

https://en.wikipedia.org/wiki/Title_42_of_the_United_States_Code

TITLE X—TRANSITION

Subtitle A—
Transitional Medicare Buy-In Option [Sanders]
And Transitional Public Option [Sanders]

SEC. 1001. LOWERING THE MEDICARE AGE.

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

"TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN INDIVIDUALS

"Sec. 1899C. (a) Option.—
"(1) IN GENERAL.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll under this section.

"(2) PART A, B, AND D BENEFITS.—An individual enrolled under this section is entitled to the same benefits (and shall receive the same protections) under this title as an individual who is entitled to benefits under part A and enrolled under parts B and D, including the ability to enroll in a Medicare Advantage plan that provides qualified prescription drug coverage (an MA–PD plan).

"(3) REQUIREMENTS FOR ELIGIBILITY.—The requirements described in this paragraph are the following:

"(A) The individual is a resident of the United States.

"(B) The individual is—

"(i) a citizen or national of the United States; or

"(ii) an alien lawfully admitted for permanent residence.

"(C) The individual is not otherwise entitled to benefits under part A or eligible to enroll under part A or part B.

"(D) The individual has attained the applicable years of age but has not attained 65 years of age.

"(4) APPLICABLE YEARS OF AGE DEFINED.—For purposes of this section, the term 'applicable years of age' means—

"(A) effective January 1 of the first year following the date of enactment of the Medicare for All Act of 2019, the age of 55;

"(B) effective January 1 of the second year following such date of enactment, the age of 45; and

"(C) effective January 1 of the third year following such date of enactment, the age of 35.

"(b) Enrollment; Coverage.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

"(c) Premium.—

"(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with the first September following the date of enactment of the Medicare for All Act of 2019), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1⁄12 of the annual premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

"(2) ANNUAL PREMIUM.—

"(A) COMBINED PER CAPITA AVERAGE FOR ALL MEDICARE BENEFITS.—The Secretary shall estimate the average, annual per capita amount for benefits and administrative expenses that will be payable under parts A, B, and D (including, as applicable, under part C) in the year for all individuals enrolled under this section.

"(B) ANNUAL PREMIUM.—The annual premium under this subsection for months in a year is equal to the average, annual per capita amount estimated under subparagraph (A) for the year.

"(3) INCREASED PREMIUM FOR CERTAIN PART C AND D PLANS.—Nothing in this section shall preclude an individual from choosing a Medicare Advantage plan or a prescription drug plan which requires the individual to pay an additional amount (because of supplemental benefits or because it is a more expensive plan). In such case the individual would be responsible for the increased monthly premium.

"(d) Payment Of Premiums.—

"(1) IN GENERAL.—Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary determines appropriate.

"(2) DEPOSIT.—Amounts collected by the Secretary under this section shall be deposited in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund) in such proportion as the Secretary determines appropriate.

"(e) Not Eligible For Medicare Cost-Sharing Assistance.—An individual enrolled under this section shall not be treated as enrolled under any part of this title for purposes of obtaining medical assistance for Medicare cost-sharing or otherwise under title XIX.

"(f) Treatment In Relation To The Affordable Care Act.—

"(1) SATISFACTION OF INDIVIDUAL MANDATE.—For purposes of applying section 5000A of the Internal Revenue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

"(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—Coverage provided under this section—

"(A) shall be treated as coverage under a qualified health plan in the individual market enrolled in through the Exchange where the individual resides for all purposes of section 36B of the Internal Revenue Code of 1986 other than subsection (c)(2)(B) thereof; and

"(B) shall not be treated as eligibility for other minimum essential coverage for purposes of subsection (c)(2)(B) of such section 36B.

The Secretary shall determine the applicable second lowest cost silver plan which shall apply to coverage under this section for purposes of section 36B of such Code.

"(3) ELIGIBILITY FOR COST-SHARING SUBSIDIES.—For purposes of applying section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071)—

"(A) coverage provided under this section shall be treated as coverage under a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

"(B) the Secretary shall be treated as the issuer of such plan.

"(g) No Effect On Benefits For Individuals Otherwise Eligible Or On Trust Funds.—The Secretary shall implement the provisions of this section in such a manner to ensure that such provisions—

"(1) have no effect on the benefits under this title for individuals who are entitled to, or enrolled for, such benefits other than through this section; and

"(2) have no negative impact on the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund).

"(h) Consultation.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing beneficiaries, health care providers, employers, and insurance companies.".

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION PLAN.

(a) In General.—To carry out the purpose of this section, for plan years beginning with the first plan year that begins after the date of enactment of this Act and ending with the effective date described in section 106, the Secretary, **acting through the Administrator of the Centers for Medicare & Medicaid** (referred to in this section as the "Administrator"), shall establish, and provide for the offering through **the Exchanges**, of a public health plan (in this Act referred to as the **"Medicare Transition plan"**) that provides affordable, high-quality health benefits coverage throughout the United States.

(b) Administrating The Medicare Transition.—

(1) ADMINISTRATOR.—The Administrator shall administer the Medicare Transition plan in accordance with this section.

(2) APPLICATION OF ACA REQUIREMENTS.—Consistent with this section, the Medicare Transition plan shall comply with requirements under title I of the Patient Protection and Affordable Care Act (and the amendments made by that title) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) that are applicable to qualified health plans offered through the Exchanges, subject to the limitation under subsection (e)(2).

(3) OFFERING THROUGH EXCHANGES.—The Medicare Transition plan shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032)) who wish to make such plan available to their employees.

(4) ELIGIBILITY TO PURCHASE.—Any United States resident may enroll in the Medicare Transition plan.

(c) Benefits; Actuarial Value.—In carrying out this section, the Administrator shall ensure that the Medicare Transition plan provides—

(1) coverage for the benefits required to be covered under title II; and

(2) coverage of benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(d) Providers And Reimbursement Rates.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition plan, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.). For items and services covered under the

Medicare Transition plan but not covered under such parts A and B, the Administrator shall reimburse providers at rates set by the Administrator in a manner consistent with the manner in which rates for other items and services were set under the original Medicare fee-for-service program.

(2) PRESCRIPTION DRUGS.—Any payment rate under this subsection for a prescription drug shall be at a rate negotiated by the Administrator with the manufacturer of the drug. If the Administrator is unable to reach a negotiated agreement on such a reimbursement rate, the Administrator shall establish the rate at an amount equal to the lesser of—

(A) the price paid by the Secretary of Veterans Affairs to procure the drug under the laws administered by the Secretary of Veterans Affairs;

(B) the price paid to procure the drug under section 8126 of title 38, United States Code; or

(C) the best price determined under section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of

this Act shall be a participating provider in the Medicare Transition plan.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition plan. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) Premiums.—

(1) DETERMINATION.—The Administrator shall determine the premium amount for enrolling in the Medicare Transition plan, which—

(A) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section 2701(a)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A))); and

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

(2) LIMITATION.—Variation in premium rates of the Medicare Transition plan by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

(f) Termination.—This section shall cease to have force or effect on the effective date described in section 106.

(g) Tax Credits And Cost-Sharing Subsidies.—

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION PLAN ENROLLEES AT OR ABOVE 44 PERCENT OF POVERTY IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULES FOR MEDICARE TRANSITION PLAN ENROLLEES.—

"(i) IN GENERAL.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, subparagraph (A) shall be applied without regard to 'but does not exceed 400 percent'.

"(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is

covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.".

(B) PREMIUM ASSISTANCE AMOUNTS FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—

(i) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of such Code is amended—

(I) by *redesignating* clause (ii) as clause (iii);

(II) by striking "clause (ii)" in clause (i) and inserting "clauses (ii) and (iii)"; and

(III) by inserting after clause (i) the following new clause:

"(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

"In the case of household income (expressed as a percent of poverty line) within the following income tier: The initial premium percentage is— The final premium percentage is—

Up to 100 percent 2 2

100 percent up to 138 percent 2.04 2.04

138 percent up to 150 percent 3.06 4.08

150 percent and above 4.08 5".

(ii) CONFORMING AMENDMENT.—Subclause (I) of clause (iii) of section 36B(b)(3) of such Code, as redesignated by subparagraph (A)(i), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(2) COST-SHARING SUBSIDIES.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(A) by inserting ", or in the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019," after "coverage" in paragraph (1);

(B) by *redesignating* paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(C) by striking "Insured.—In this section" and inserting "Insured.—

"(1) IN GENERAL.—In this section";

(D) by striking the flush language; and

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

"(2) SPECIAL RULES.—

"(A) INDIVIDUALS LAWFULLY PRESENT.—In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent of the poverty line for a family of the size involved for purposes of applying this section.

"(B) MEDICARE TRANSITION PLAN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition plan, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.

"(C) ADJUSTED COST-SHARING FOR MEDICARE TRANSITION PLAN ENROLLEES.—In the case of any individual who enrolls in such Medicare Transition plan, in lieu

of the percentages under subsection (c)(1)(B)(i) and (c)(2), the Secretary shall prescribe a method of determining the cost-sharing reduction for any such individual such that the total of the cost-sharing and the premiums paid by the individual under such Medicare Transition plan does not exceed the percentage of the total allowed costs of benefits provided under the plan equal to the final premium percentage applicable to such individual under section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986.”.

(h) Conforming Amendments.—

(1) TREATMENT AS A QUALIFIED HEALTH PLAN.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(2)) is amended—

(A) in the paragraph heading, by inserting “, THE MEDICARE TRANSITION PLAN,” before “AND”; and

(B) by inserting “The Medicare Transition plan,” before “and a multi-State plan”.

(2) LEVEL PLAYING FIELD.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting “the Medicare Transition plan,” before “or a multi-State qualified health plan”.

Subtitle B—Transitional Medicare Reforms

MISSING sec. 1003 TO SEC. 1010

SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR FEE-FOR-SERVICE BENEFITS AND ELIMINATION OF PARTS A AND B DEDUCTIBLES.

(a) Protection Against High Out-Of-Pocket Expenditures.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 1001, is amended by adding at the end the following new section:

"PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES … "Sec. 1899D. (a) In General.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (effective the year beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019) equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing occurred during that year.

"(b) Out-Of-Pocket Cost-Sharing Defined.—

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

"(A) coinsurance and copayments applicable under part A or B; or

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

"(2) CERTAIN COSTS NOT INCLUDED.—

"(A) NON-COVERED ITEMS AND SERVICES.—Expenses incurred for items and services which are not included (or treated as being included) under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

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

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

(b) Elimination Of Parts A And B Deductibles.—

(1) PART A.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended by adding at the end the following new paragraph:

"(4) For each year (beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019), the inpatient hospital deductible for the year shall be $0.".

(2) PART B.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended, in the first sentence—

(A) by striking "and for a subsequent year" and inserting "for each of 2006 through the year that includes the date of enactment of the Medicare for All Act of 2019"; and

(B) by inserting ", and $0 for each year subsequent year" after "$1)".

SEC. 1012. REDUCTION IN MEDICARE PART D ANNUAL OUT-OF-POCKET THRESHOLD AND ELIMINATION OF COST-SHARING ABOVE THAT THRESHOLD.

(a) Reduction.—Section 1860D–2(b)(4)(B) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)) is amended—

(1) in clause (i), by striking "For purposes" and inserting "Subject to clause (iii), for purposes"; and

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

"(iii) REDUCTION IN THRESHOLD DURING TRANSITION PERIOD.—

"(I) IN GENERAL.—Subject to subclause (II), for plan years beginning on or after January 1 following the date of enactment of the Medicare for All Act of 2019 and before January 1 of the year that is 4 years following such date of enactment, notwithstanding clauses (i) and (ii), the 'annual out-of-pocket threshold' specified in this subparagraph is equal to $305.

"(II) AUTHORITY TO EXEMPT BRAND-NAME DRUGS IF GENERIC AVAILABLE.—In applying subclause (I), the Secretary may exempt costs incurred for a covered part D drug that is an applicable drug under section 1860D–14A(g)(2) if the

Secretary determines that a generic version of that drug is available.”.

(b) Elimination Of Cost-Sharing.—Section 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(A)) is amended—

(1) in clause (i)—

(A) by *redesignating* subclauses (I) and (II) as items (aa) and (bb), respectively;

(B) by striking “subparagraph (B), with cost-sharing” and inserting the following: “subparagraph (B)—

“(I) for plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, with cost-sharing”;

(C) in item (bb), as *redesignated* by subparagraph (A), by striking the period at the end and inserting “; and”; and

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

“(II) for the plan year beginning January 1 following the date of enactment of the Medicare for All Act of 2019 and the two subsequent plan years, without any cost-sharing.”; and

(2) in clause (ii)—

(A) by striking “clause (i)(I)” and inserting “clause (i)(I)(aa)”; and

(B) by adding at the end the following new sentence: “The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this

clause, after plan year 2018 for purposes of 1860D–14(a)(1)(D)(iii).”.

(c) Conforming Amendments To Low-Income Subsidy.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (D)(iii), by striking “1860D–2(b)(4)(A)(i)(I)” and inserting “1860D–2(b)(4)(A)(i)(I)(aa)”; and

(B) in subparagraph (E)—

(i) in the heading, by inserting “PRIOR TO THE ELIMINATION OF SUCH COST-SHARING FOR ALL INDIVIDUALS” after “THRESHOLD”; and

(ii) by striking “The elimination” and inserting “For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, the elimination”; and

(2) in paragraph (2)(E)—

(A) in the heading, by inserting “PRIOR TO THE ELIMINATION OF SUCH COST-SHARING FOR ALL INDIVIDUALS” after “THRESHOLD”;

(B) by striking “Subject to” and inserting “For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, subject to”; and

(C) by striking “1860D–2(b)(4)(A)(i)(I)” and inserting “1860D–2(b)(4)(A)(i)(I)(aa)”.

SEC. 1013. COVERAGE OF DENTAL AND VISION SERVICES AND HEARING AIDS AND EXAMINATIONS UNDER MEDICARE PART B.

(a) Dental Services.—

(1) REMOVAL OF EXCLUSION FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by striking paragraph (12).

(2) COVERAGE.—
(A) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(i) in subparagraph (GG), by striking “and” at the end;

(ii) in subparagraph (HH), by striking the period at the end and inserting “; and”; and

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

“(II) dental services;”.

(B) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking “and” before “(CC)”; and

(ii) by inserting before the semicolon at the end the following: “, and (DD) with respect to dental services described in section 1861(s)(2)(II), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the

amount determined under the fee schedule established under section 1848(b).”.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

(b) Vision Services.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by subsection (a), is amended—

(A) in subparagraph (HH), by striking “and” at the end;

(B) in subparagraph (II), by inserting “and” at the end; and

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

“(JJ) vision services;”.

(2) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is amended—

(A) by striking “and” before “(DD)”; and

(B) by inserting before the semicolon at the end the following: “, and (EE) with respect to vision services described in section 1861(s)(2)(JJ), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

(c) Hearing Aids And Examinations Therefor.—

(1) IN GENERAL.—Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by striking "hearing aids or examinations therefor,".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

SEC. 1014. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) In General.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking ", and has for 24 calendar months been entitled to,";

(2) in paragraph (2)(B), by striking ", and has been for not less than 24 months,";

(3) in paragraph (2)(C)(ii), by striking ", including the requirement that he has been entitled to the specified benefits for 24 months,";

(4) in the first sentence, by striking "for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and" and inserting "for

each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and"; and

(5) in the second sentence, by striking "the 'twenty-fifth month of his entitlement'" and all that follows through "paragraph (2)(C) and".

(b) Conforming Amendments.—

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

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) *redesignating* subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking "have been entitled for not less than 24 months" and inserting "are entitled".

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking "25th month of" and inserting "month following the first month of".

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking “has been entitled to an annuity” and inserting “is entitled to an annuity”;

(B) by striking “, for not less than 24 months”; and

(C) by striking “could have been entitled for 24 calendar months, and”.

(c) Effective Date.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before January 1 of the year that is 4 years after such date of enactment.

SEC. 1015. GUARANTEED ISSUE OF MEDIGAP POLICIES.

add >> ["MEDIGAP POLICIES" : https://www.cms.gov/Medicare/Health-Plans/Medigap]

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

MISSING SEC. 1016 TO SEC. 1021

“(aa) Guaranteed Issue For All Medigap-Eligible Medicare Beneficiaries.—Notwithstanding paragraphs (2)(A) and (2)(D) of subsection (s) or any other provision of this section, on or after the date of enactment of this subsection, the issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or

discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of any individual entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B.”.

Subtitle C—Private Health Insurance Availability During Transitional Period

SEC. 1021. CONTINUITY OF CARE.

(a) In General.—The Secretary shall ensure that all individuals enrolled in, or who seek to enroll in, a group health plan, health insurance coverage offered by a health insurance issuer, or the plan established under section 1002 during the transition period of this Act are protected from disruptions in their care during the transition period.

(b) Public Consultation During Transition.—The Secretary shall consult with communities and advocacy organizations of individuals living with disabilities and other patient advocacy organizations to ensure the transition described in this section takes into account the continuity of care for individuals with disabilities, complex medical needs, or chronic conditions.

(c) Definitions.—In this section, the terms “health insurance coverage”, “health insurance issuer”, and “group health plans” have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

[END TITLEX – TRANSITION]