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115TH CONGRESS
1ST SESSION

H. R. 3748

To amend title XVIII of the Social Security Act to provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 2017

Mr. HIGGINS of New York (for himself, Mr. LARSON of Connecticut, Mr. COURTNEY, Mr. CARSON of Indiana, Mr. CICILLINE, Mr. COHEN, Ms. DELAURO, Mr. DEUTCH, Mr. HUFFMAN, Ms. KAPTUR, Mr. KEATING, Mr. KHANNA, Mr. KRISHNAMOORTHI, Ms. MCCOLLUM, Mr. MCEACHIN, Mr. MCGOVERN, Mr. PERLMUTTER, Mr. PRICE of North Carolina, Mr. QUIGLEY, Mr. RYAN of Ohio, Ms. TITUS, Mr. TONKO, Mr. WELCH, Mr. DELANEY, Ms. PINGREE, Ms. ESTY of Connecticut, Mr. LOWENTHAL, Mr. KIHUEN, Mrs. NAPOLITANO, Mr. SEAN PATRICK MALONEY of New York, Mr. GARAMENDI, Ms. SHEA-PORTER, Mr. PETERSON, Mr. POLIS, and Mr. HECK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, 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 provide for an option for individuals who are ages 50 to 64 to buy into Medicare, to provide for health insurance market stabilization, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Buy-In and Health Care Stabilization Act of 2017''.

SEC. 2. MEDICARE BUY-IN OPTION.

(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:

''MEDICARE BUY-IN OPTION

''SEC. 1899C. (a) OPTION.—

''(1) ELIGIBILITY.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll under this section.

''(2) IN GENERAL.—An individual who meets the following requirements is eligible to enroll under this section:

''(A) AGE.—The individual has attained 50 years of age, but has not attained 65 years of age.

''(B) MEDICARE ELIGIBILITY (BUT FOR AGE).—The individual is not otherwise entitled to benefits under part A or eligible to enroll under part A or part B but would be eligible for benefits under part A or part B if the individual were 65 years of age.

''(3) BENEFITS.—An individual enrolled under this section is entitled to the same benefits under

this title as an individual who is entitled to benefits under part A and enrolled under parts B and D.

''(b) ENROLLMENT AND COVERAGE PERIODS.—The Secretary shall establish enrollment and coverage periods for individuals who enroll under this section. Such periods shall be established in coordination with the enrollment and coverage periods for plans offered under an Exchange established under title I of the Patient Protection and Affordable Care Act. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the first year beginning at least one year after the date of the enactment of this section.

''(c) BUY-IN PREMIUM.—

''(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall (beginning for the first year that begins more than 1 year after the date of the enactment of this section), during September of the preceding year, determine a monthly premium for 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 such year.

''(2) ANNUAL PREMIUM.—

''(A) COMBINED NATIONAL, PER CAPITA AVERAGE FOR PARTS A, B, AND D 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 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.

''(C) ADJUSTMENTS.—The Secretary shall adjust the annual premium under this subsection as necessary—

''(i) to ensure that expenditures under this title for any year are not increased by reason of this section; and

''(ii) by a geographic adjustment factor to address regional affordability concerns.

''(3) ADDITIONAL PREMIUM FOR CERTAIN D PLANS.—Nothing in this section shall preclude an individual from choosing a prescription drug plan which requires the individual to pay an additional

amount (because of the inclusion of supplemental prescription drug benefits or because the plan is a more expensive plan, pursuant to section 1860D–13(a)(1)). In such case, the monthly premium under paragraph (1) shall be increased with respect to such individual.

''(d) PAYMENT OF PREMIUMS.—

''(1) PAYMENT.—

''(A) 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.

''(B) PAYMENT OF PREMIUMS BY EMPLOYERS ON BEHALF OF EMPLOYEES.—An employer of an individual who enrolls under this section may make payments for the premiums for such enrollment on behalf of such individual pursuant to a process established by the Secretary. Such process shall ensure that enrollment under this section is the choice of the individual and not the employer.

''(2) DEPOSIT.—Amounts collected by the Secretary under this section shall be deposited in the Medicare Buy-In Trust Fund established under subsection (e).

''(e) MEDICARE BUY-IN TRUST FUND.—

''(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Buy-In Trust Fund' (in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

''(2) PREMIUMS.—Premiums collected under subsection (d) shall be transferred to the Trust Fund.

''(3) INCORPORATION OF PROVISIONS.—Subsections (b) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively, except that in applying such section 1841, any reference in such section to 'this part' shall be construed to be a reference to this section and any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed to be references to comparable authority exercised under this section.

''(f) CLARIFICATION.—Nothing in this section shall affect the benefits or eligibility under this title of individuals who would otherwise be entitled to or eligible for benefits under this title or title XIX, or both.

''(g) 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 through enrollment under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section.

''(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—Coverage provided through enrollment 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 provided through enrollment 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—

''(A) coverage provided through enrollment under this part and parts B and D pursuant to 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.

''(4) USE OF EXCHANGES.—Coverage provided through enrollment under this section shall be deemed to be coverage under a qualified health plan for purposes of section 1311(d)(4)(C) of the Patient Protection and Affordable Care Act and shall be made available for enrollment, information comparison, and otherwise as such a plan through any Internet website maintained by an Exchange established under title I of such Act (as described in such section).

''(5) ACCESS TO MEDIGAP.—Coverage provided through medicare supplemental policies certified under section 1882 shall be made available to individuals eligible for enrollment pursuant to this section for enrollment, information, comparison, and otherwise as such a policy through any Internet website described in paragraph (4).

''(h) OVERSIGHT.—There is established an advisory committee to be known as the 'Medicare Buy In Oversight Board' to monitor and oversee the implementation of this section, including the experience of the individuals enrolling under this section. The Medicare Buy In Oversight Board shall make periodic recommendations for the continual improvement of the implementation of this section as well as the relationship of enrollment under this section to other health care programs.

''(i) OUTREACH AND ENROLLMENT.—

''(1) IN GENERAL.—During the period that begins on January 1, 2018, and ends on December 31, 2020, the Secretary shall award grants to eligible entities for the following purposes:

''(A) OUTREACH AND ENROLLMENT.—To carry out outreach, public education activities, and enrollment activities to raise awareness of

the availability of, and encourage, enrollment under this section.

''(B) ASSISTING INDIVIDUALS TRANSITION UNDER THIS SECTION.—To provide assistance to individuals to enroll under this section.

''(C) RAISING AWARENESS OF PREMIUM ASSISTANCE AND COST-SHARING REDUCTIONS.—To distribute fair and impartial information concerning enrollment under this section and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

''(2) ELIGIBLE ENTITIES.—

''(A) IN GENERAL.—In this subsection, the term 'eligible entity' means—

''(i) a State; or

''(ii) a nonprofit community-based organization.

''(B) ENROLLMENT AGENTS.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State

or nonprofit community-based organization to enroll eligible individuals under this section.

''(C) EXCLUSIONS.—Such term does not include an entity that—

''(i) is a health insurance issuer; or

''(ii) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any individuals under this section.

''(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to awarding grants to States or eligible entities in States that have geographic rating areas at risk of having no qualified health plans in the individual market.

''(4) FUNDING.—Out of any moneys in the Treasury not otherwise appropriated, $500,000,000 is appropriated to the Secretary for each of calendar years 2018 through 2020, to carry out this subsection.

''(j) IMPLEMENTATION.—

''(1) CONSULTATION.—In carrying out this section, the Secretary shall—

''(A) consult with other Federal agencies, including the Department of the Treasury, the Department of Labor, the Department of Veterans Affairs, the Department of Defense, and the Office of Personnel Management; and

''(B) incorporate significant public consultation and feedback, through public forums, notice and comment rulemaking, and any other appropriate mediums.

''(2) REPORT.—No later than one year after the date of the enactment of this section, the Secretary shall submit to Congress a report establishing the administrative parameters for the implementation of this section.

''(k) FEASIBILITY STUDY.—The Secretary shall conduct a study on the feasibility of applying this section with respect to individuals residing in States that are not within the 50 States or the District of Columbia.''.

(b) MEDIGAP.—Section 1882 of the Social Security Act is amended by adding at the end the following new subsection:

''(aa) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES RELATING TO BUY-IN OPTION.—The Secretary shall request the National Association of Insurance Commissioners to review

and revise the standards for benefit packages described in subsection (p)(1), to otherwise update standards to include requirements for each medicare supplemental policy that offers such a policy in a State, with respect to each year, to accept every individual in the State who is eligible for enrollment pursuant to section 1899C and who applies for such coverage for such year if the individual applies for enrollment in such policy during the 30-day period following the date of enrollment pursuant to section 1899C and to accept every such individual during a period of transition from enrollment pursuant to such section to enrollment under this title pursuant to eligibility other than under such section. Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of this subsection (aa).''.

SEC. 3. NEGOTIATION OF LOWER COVERED PART D DRUG PRICES ON BEHALF OF MEDICARE BENEFICIARIES.

(a) NEGOTIATION BY SECRETARY.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) (relating to noninterference) and inserting the following:

''(i) NEGOTIATION OF LOWER DRUG PRICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA–PD plan.

''(2) NO CHANGE IN RULES FOR FORMULARIES.—

''(A) IN GENERAL.—Nothing in paragraph (1) shall be construed to authorize the Secretary to establish or require a particular formulary.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as affecting the Secretary's authority to ensure appropriate and adequate access to covered part D drugs under

prescription drug plans and under MA–PD plans, including compliance of such plans with formulary requirements under section 1860D–4(b)(3).

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the sponsor of a prescription drug plan, or an organization offering an MA–PD plan, from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated under paragraph (1).

''(4) SEMI-ANNUAL REPORTS TO CONGRESS.—Not later than June 1, 2018, and every 6 months thereafter, the Secretary shall submit to the Committees on Ways and Means, Energy and Commerce, and Oversight and Government Reform of the House of Representatives and the Committee on Finance of the Senate a report on negotiations conducted by the Secretary to achieve lower prices for Medicare beneficiaries, and the prices and price discounts achieved by the Secretary as a result of such negotiations.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall first apply to negotiations and prices for plan years beginning on January 1, 2018.

SEC. 4. INDIVIDUAL MARKET REINSURANCE FUND.

(a) ESTABLISHMENT OF FUND.—

(1) IN GENERAL.—There is established the ''Individual Market Reinsurance Fund'' (in this section referred to as the ''Fund'') to be administered by the Secretary to provide funding for an individual market stabilization reinsurance program in each State that complies with the requirements of this section.

(2) FUNDING.—Amounts made available to the Fund shall consist of the funds deposited into the Fund under paragraph (3) and shall be used to carry out this section (other than subsection (c)) for each calendar year beginning with 2018. Amounts made available to the Fund shall remain available without fiscal or calendar year limitation to carry out this section.

(3) COST-SHARING IN COSTS OF PROGRAM.—

(A) IN GENERAL.—A qualified health plan that participates in the reinsurance program established under subsection (b) shall pay the fee established under subparagraph (B).

(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each qualified health plan that participates in the reinsurance program established under subsection (b). Any

amounts collected pursuant to this paragraph shall be deposited into the Fund for purposes of payments under subsection (b).

(C) REQUIREMENTS.—In establishing the fee under subparagraph (B)—

(i) the Secretary shall consult with interested parties; and

(ii) shall ensure that the amount of such fee is not excessive so as to unduly discourage qualified health plans from participating in the reinsurance program.

(b) INDIVIDUAL MARKET REINSURANCE PROGRAM.—

(1) USE OF FUNDS.—The Secretary shall use amounts in the Fund to establish a reinsurance program under which the Secretary shall make reinsurance payments, subject to subsection (a)(3), to health insurance issuers with respect to high-cost individuals enrolled in qualified health plans offered by such issuers that are not grandfathered health plans or transitional health plans for any plan year beginning with the 2018 plan year. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Sec-

retary to provide payments from the Fund in accordance with this subsection.

(2) AMOUNT OF PAYMENT.—The payment made to a health insurance issuer under paragraph (1) with respect to each high-cost individual enrolled in a qualified health plan issued by the issuer that is not a grandfathered health plan or a transitional health plan shall equal 80 percent of the lesser of—

(A) the amount (if any) by which the individual's claims incurred during the plan year exceeds—

(i) in the case of the 2018, 2019, or 2020 plan year, $50,000; and

(ii) in the case of any other plan year, $100,000; or

(B) for plan years described in—

(i) subparagraph (A)(i), $450,000; and

(ii) subparagraph (A)(ii), $400,000.

(3) INDEXING.—In the case of plan years beginning after 2018, the dollar amounts that appear in subparagraphs (A) and (B) of paragraph (2) shall each be increased by an amount equal to—

(A) such amount; multiplied by

(B) the premium adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting ''2018'' for ''2013''.

(4) PAYMENT METHODS.—

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

(B) REQUIREMENT FOR PROVISION OF INFORMATION.—

(i) REQUIREMENT.—Payments under this subsection to a health insurance issuer are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this subsection.

(ii) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to clause (i) is subject to

the HIPAA privacy and security law, as defined in section 3009(a) of the Public Health Service Act (42 U.S.C. 300jj–19(a)).

(5) SECRETARY FLEXIBILITY FOR BUDGET NEUTRAL REVISIONS TO REINSURANCE PAYMENT SPECIFICATIONS.—If the Secretary determines appropriate, the Secretary may substitute higher dollar amounts for the dollar amounts specified under subparagraphs (A) and (B) of paragraph (2) (and adjusted under paragraph (3), if applicable) if the Secretary certifies that such substitutions, considered together, neither increase nor decease the total projected payments under this subsection.

(c) REPORTS TO CONGRESS.—

(1) ANNUAL REPORT.—The Secretary shall submit a report to Congress, not later than January 21, 2019, and each year thereafter, that contains the following information for the most recently ended year:

(A) The number and types of plans in each State's individual market, specifying the number that are qualified health plans, grandfathered health plans, or health insurance coverage that is not a qualified health plan.

(B) The impact of the reinsurance payments provided under this section on the availability of coverage, cost of coverage, and coverage options in each State.

(C) The amount of premiums paid by individuals in each State by age, family size, geographic area in the State's individual market, and category of health plan (as described in subparagraph (A)).

(D) The process used to award funds for outreach and enrollment activities awarded to eligible entities under subsection (c), the amount of such funds awarded, and the activities carried out with such funds.

(E) Such other information as the Secretary deems relevant.

(2) EVALUATION REPORT.—Not later than January 31, 2022, the Secretary shall submit to Congress a report that—

(A) analyzes the impact of the funds provided under this section on premiums and enrollment in the individual market in all States; and

(B) contains a State-by-State comparison of the design of the programs carried out by States with funds provided under this section.

(d) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Department of Health and Human Services.

(2) FUND.—The term ''Fund'' means the Individual Market Reinsurance Fund established under subsection (a).

(3) GRANDFATHERED HEALTH PLAN.—The term ''grandfathered health plan'' has the meaning given that term in section 1251(e) of the Patient Protection and Affordable Care Act.

(4) HIGH-COST INDIVIDUAL.—The term ''high-cost individual'' means an individual enrolled in a qualified health plan (other than a grandfathered health plan or a transitional health plan) who incurs claims in excess of $50,000 during a plan year.

(5) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(6) TRANSITIONAL HEALTH PLAN.—The term ''transitional health plan'' means a plan continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the

State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 of the Patient Protection and Affordable Care Act does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, and February 13, 2017.

SEC. 5. REAUTHORIZATION OF RISK CORRIDORS.

Section 1342(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18062(a)) is amended by inserting ''and calendar years 2018 through 2020'' after ''2016''.

SEC. 6. ENHANCEMENTS FOR REDUCED COST SHARING.

(a) MODIFICATION OF AMOUNT.—

(1) IN GENERAL.—Section 1402(c)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(c)(2)) is amended to read as follows:

''(2) ADDITIONAL REDUCTION.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

''(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 95 percent of such costs;

''(B) in the case of an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

''(C) in the case of an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 85 percent of such costs.''.

(2) CONFORMING AMENDMENT.—Clause (i) of section 1402(c)(1)(B) of such Act (42 U.S.C. 18071(c)(1)(B)) is amended to read as follows:

"(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

"(I) 95 percent in the case of an eligible insured described in paragraph (2)(A);

"(II) 90 percent in the case of an eligible insured described in paragraph (2)(B); and

"(III) 85 percent in the case of an eligible insured described in paragraph (2)(C).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2017.

(b) FUNDING.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

"(g) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary such sums as may be necessary for payments under this section.".

SEC. 7. TECHNICAL ADVISORY COMMITTEE ON HEALTH CARE DELIVERY SYSTEM REFORM AND PROGRAM INTEGRITY.

(a) ESTABLISHMENT.—There is established a committee to be known as the Committee on Delivery System Reform and Program Integrity.

(b) MEMBERSHIP.—The Committee shall be composed of 11 members appointed by the Comptroller General of the United States. Such members shall include individuals with national recognition for their expertise in health care delivery system reform and the related delivery of health care. Health care providers and patient advocates shall have adequate representation on the Committee.

(c) DUTIES.—The Committee shall periodically submit to the Secretary of Health and Human Services and the Congress written recommendations, provided in a comprehensive report format, to further the goals of health care delivery system reform that generally aim to improve the quality of patient care, improve the health of populations, and reduce the cost of care. The origin of these proposals can be derived from any initiative underway between the Department of Health and Human Services and any party, or other initiatives, national or regional in scope, that offer promise to accelerate the goals of delivery system reform or improve program integrity toward the

goal of providing further stability to the appropriate Trust Funds under title XVIII of the Social Security Act.

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