

116TH CONGRESS  
1ST SESSION

# H. R. 1384

To establish an improved Medicare for All national health insurance program.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 27, 2019

Ms. JAYAPAL (for herself, Mrs. DINGELL, Ms. ADAMS, Ms. BARRAGÁN, Ms. BASS, Mrs. BEATTY, Mr. BEYER, Mr. BLUMENAUER, Ms. BONAMICI, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. BROWN of Maryland, Mr. CARSON of Indiana, Mr. CARTWRIGHT, Ms. JUDY CHU of California, Mr. CICILLINE, Ms. CLARK of Massachusetts, Ms. CLARKE of New York, Mr. CLAY, Mr. CLEAVER, Mr. COHEN, Mr. DANNY K. DAVIS of Illinois, Mr. DEFazio, Ms. DEGETTE, Mr. DESAULNIER, Mr. MICHAEL F. DOYLE of Pennsylvania, Mr. ENGEL, Ms. ESCOBAR, Mr. ESPAILLAT, Ms. FRANKEL, Ms. FUDGE, Ms. GABBARD, Mr. GALLEGRO, Mr. GARCÍA of Illinois, Mr. GOLDEN, Mr. GOMEZ, Mr. GONZALEZ of Texas, Mr. GREEN of Texas, Mr. GRIJALVA, Ms. HAALAND, Mr. HARDER of California, Mr. HASTINGS, Mrs. HAYES, Mr. HIGGINS of New York, Ms. HILL of California, Ms. NORTON, Mr. HUFFMAN, Ms. JACKSON LEE, Mr. JOHNSON of Georgia, Mr. KEATING, Ms. KELLY of Illinois, Mr. KENNEDY, Mr. KHANNA, Mrs. KIRKPATRICK, Mr. LANGEVIN, Mrs. LAWRENCE, Ms. LEE of California, Mr. LEVIN of California, Mr. LEVIN of Michigan, Mr. LEWIS, Mr. TED LIEU of California, Mr. LOWENTHAL, Mrs. LOWEY, Mrs. CAROLYN B. MALONEY of New York, Mr. MCGOVERN, Mr. MCNERNEY, Mr. MEEKS, Ms. MENG, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PANETTA, Mr. PAYNE, Mr. PERLMUTTER, Ms. PINGREE, Mr. POCAN, Ms. PORTER, Ms. PRESSLEY, Mr. RASKIN, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. RYAN, Mr. SABLAN, Ms. SÁNCHEZ, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SMITH of Washington, Ms. SPEIER, Mr. SWALWELL of California, Mr. TAKANO, Mr. THOMPSON of California, Mr. THOMPSON of Mississippi, Ms. TITUS, Ms. TLAIB, Mr. TONKO, Mr. VEASEY, Ms. VELÁZQUEZ, Mr. VISCLOSKEY, Ms. WATERS, Mrs. WATSON COLEMAN, Mr. WELCH, Ms. WILD, and Ms. WILSON of Florida) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Rules, Oversight and Reform, and Armed Services, 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

# A BILL

To establish an improved Medicare for All national health insurance program.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
 5 “Medicare for All Act of 2019”.

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

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL  
 PROGRAM; UNIVERSAL COVERAGE; ENROLLMENT

Sec. 101. Establishment of the Medicare for All Program.

Sec. 102. Universal coverage.

Sec. 103. Freedom of choice.

Sec. 104. Non-discrimination.

Sec. 105. Enrollment.

Sec. 106. Effective date of benefits.

Sec. 107. Prohibition against duplicating coverage.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE  
 BENEFITS AND BENEFITS FOR LONG-TERM CARE

Sec. 201. Comprehensive benefits.

Sec. 202. No cost-sharing.

Sec. 203. Exclusions and limitations.

Sec. 204. Coverage of long-term care services.

TITLE III—PROVIDER PARTICIPATION

Sec. 301. Provider participation and standards; whistleblower protections.

Sec. 302. Qualifications for providers.

Sec. 303. Use of private contracts.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

Sec. 401. Administration.

Sec. 402. Consultation.

Sec. 403. Regional administration.

Sec. 404. Beneficiary ombudsman.

Sec. 405. Conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

Sec. 411. Application of Federal sanctions to all fraud and abuse under the Medicare for All Program.

TITLE V—QUALITY ASSESSMENT

Sec. 501. Quality standards.

Sec. 502. Addressing health care disparities.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

Sec. 601. National health budget.

Subtitle B—Payments to Providers

Sec. 611. Payments to institutional providers based on global budgets.

Sec. 612. Payment to individual providers through fee-for-service.

Sec. 613. Ensuring accurate valuation of services under the Medicare physician fee schedule.

Sec. 614. Payment prohibitions; capital expenditures; special projects.

Sec. 615. Office of primary health care.

Sec. 616. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Sec. 701. Universal Medicare Trust Fund.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 801. Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers' compensation.

Sec. 802. Application of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.

Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

Sec. 901. Relationship to existing Federal health programs.

Sec. 902. Sunset of provisions related to the State Exchanges.

Sec. 903. Sunset of provisions related to pay for performance programs.

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

Sec. 1001. Medicare for all transition over two years.

Sec. 1002. Establishment of the Medicare transition buy-in.

Subtitle B—Transitional Medicare Reforms

Sec. 1011. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.

Sec. 1012. Ensuring continuity of care.

#### TITLE XI—MISCELLANEOUS

Sec. 1101. Definitions.

Sec. 1102. Rules of construction.

# 1 **TITLE I—ESTABLISHMENT OF** 2 **THE MEDICARE FOR ALL PRO-** 3 **GRAM; UNIVERSAL COVER-** 4 **AGE; ENROLLMENT**

## 5 **SEC. 101. ESTABLISHMENT OF THE MEDICARE FOR ALL** 6 **PROGRAM.**

7 There is hereby established a national health insur-  
8 ance program to provide comprehensive protection against  
9 the costs of health care and health-related services, in ac-  
10 cordance with the standards specified in, or established  
11 under, this Act.

## 12 **SEC. 102. UNIVERSAL COVERAGE.**

13 (a) **IN GENERAL.**—Every individual who is a resident  
14 of the United States is entitled to benefits for health care  
15 services under this Act. The Secretary shall promulgate  
16 a rule that provides criteria for determining residency for  
17 eligibility purposes under this Act.

18 (b) **TREATMENT OF OTHER INDIVIDUALS.**—The Sec-  
19 retary may make eligible for benefits for health care serv-  
20 ices under this Act other individuals not described in sub-  
21 section (a), and regulate the eligibility of such individuals,  
22 to ensure that every person in the United States has ac-

1 cess to health care. In regulating such eligibility, the Sec-  
2 retary shall ensure that individuals are not allowed to  
3 travel to the United States for the sole purpose of obtain-  
4 ing health care items and services provided under the pro-  
5 gram established under this Act.

6 **SEC. 103. FREEDOM OF CHOICE.**

7 Any individual entitled to benefits under this Act may  
8 obtain health services from any institution, agency, or in-  
9 dividual qualified to participate under this Act.

10 **SEC. 104. NON-DISCRIMINATION.**

11 (a) IN GENERAL.—No person shall, on the basis of  
12 race, color, national origin, age, disability, marital status,  
13 citizenship status, primary language use, genetic condi-  
14 tions, previous or existing medical conditions, religion, or  
15 sex, including sex stereotyping, gender identity, sexual ori-  
16 entation, and pregnancy and related medical conditions  
17 (including termination of pregnancy), be excluded from  
18 participation in or be denied the benefits of the program  
19 established under this Act (except as expressly authorized  
20 by this Act for purposes of enforcing eligibility standards  
21 described in section 102), or be subject to any reduction  
22 of benefits or other discrimination by any participating  
23 provider (as defined in section 301), or any entity con-  
24 ducting, administering, or funding a health program or

1 activity, including contracts of insurance, pursuant to this  
2 Act.

3 (b) CLAIMS OF DISCRIMINATION.—

4 (1) IN GENERAL.—The Secretary shall establish  
5 a procedure for adjudication of administrative com-  
6 plaints alleging a violation of subsection (a).

7 (2) JURISDICTION.—Any person aggrieved by a  
8 violation of subsection (a) by a covered entity may  
9 file suit in any district court of the United States  
10 having jurisdiction of the parties. A person may  
11 bring an action under this paragraph concurrently  
12 as such administrative remedies as established in  
13 paragraph (1).

14 (3) DAMAGES.—If the court finds a violation of  
15 subsection (a), the court may grant compensatory  
16 and punitive damages, declaratory relief, injunctive  
17 relief, attorneys' fees and costs, or other relief as ap-  
18 propriate.

19 (c) CONTINUED APPLICATION OF LAWS.—Nothing in  
20 this title (or an amendment made by this title) shall be  
21 construed to invalidate or otherwise limit any of the rights,  
22 remedies, procedures, or legal standards available to indi-  
23 viduals aggrieved under section 1557 of the Patient Pro-  
24 tection and Affordable Care Act (42 U.S.C. 18116), title  
25 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et

1 seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.  
2 2000e et seq.), title IX of the Education Amendments of  
3 1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-  
4 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-  
5 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing  
6 in this title (or an amendment to this title) shall be con-  
7 strued to supersede State laws that provide additional pro-  
8 tections against discrimination on any basis described in  
9 subsection (a).

10 **SEC. 105. ENROLLMENT.**

11 (a) IN GENERAL.—The Secretary shall provide a  
12 mechanism for the enrollment of individuals eligible for  
13 benefits under this Act. The mechanism shall—

14 (1) include a process for the automatic enroll-  
15 ment of individuals at the time of birth in the  
16 United States (or upon establishment of residency in  
17 the United States);

18 (2) provide for the enrollment, as of the dates  
19 described in section 106, of all individuals who are  
20 eligible to be enrolled as of such dates, as applicable;  
21 and

22 (3) include a process for the enrollment of indi-  
23 viduals made eligible for health care services under  
24 section 102(b).

1 (b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—  
2 In conjunction with an individual’s enrollment for benefits  
3 under this Act, the Secretary shall provide for the issuance  
4 of a Universal Medicare card that shall be used for pur-  
5 poses of identification and processing of claims for bene-  
6 fits under this program. The card shall not include an in-  
7 dividual’s Social Security number.

8 **SEC. 106. EFFECTIVE DATE OF BENEFITS.**

9 (a) IN GENERAL.—Except as provided in subsection  
10 (b), benefits shall first be available under this Act for  
11 items and services furnished 2 years after the date of the  
12 enactment of this Act.

13 (b) COVERAGE FOR CERTAIN INDIVIDUALS.—

14 (1) IN GENERAL.—For any eligible individual  
15 who—

16 (A) has not yet attained the age of 19 as  
17 of the date that is 1 year after the date of the  
18 enactment of this Act; or

19 (B) has attained the age of 55 as of the  
20 date that is 1 year after the date of the enact-  
21 ment of this Act,

22 benefits shall first be available under this Act for  
23 items and services furnished as of such date.

24 (2) OPTION TO CONTINUE IN OTHER COVERAGE  
25 DURING TRANSITION PERIOD.—Any person who is



1 eligible to receive benefits as described in paragraph  
2 (1) may opt to maintain any coverage described in  
3 section 901, private health insurance coverage, or  
4 coverage offered pursuant to subtitle A of title X  
5 (including the amendments made by such subtitle)  
6 until the date described in subsection (a).

7 **SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.**

8 (a) IN GENERAL.—Beginning on the effective date  
9 described in section 106(a), it shall be unlawful for—

10 (1) a private health insurer to sell health insur-  
11 ance coverage that duplicates the benefits provided  
12 under this Act; or

13 (2) an employer to provide benefits for an em-  
14 ployee, former employee, or the dependents of an  
15 employee or former employee that duplicate the ben-  
16 efits provided under this Act.

17 (b) CONSTRUCTION.—Nothing in this Act shall be  
18 construed as prohibiting the sale of health insurance cov-  
19 erage for any additional benefits not covered by this Act,  
20 including additional benefits that an employer may provide  
21 to employees or their dependents, or to former employees  
22 or their dependents.

1 **TITLE II—COMPREHENSIVE BEN-**  
2 **EFITS, INCLUDING PREVEN-**  
3 **TIVE BENEFITS AND BENE-**  
4 **FITS FOR LONG-TERM CARE**

5 **SEC. 201. COMPREHENSIVE BENEFITS.**

6 (a) IN GENERAL.—Subject to the other provisions of  
7 this title and titles IV through IX, individuals enrolled for  
8 benefits under this Act are entitled to have payment made  
9 by the Secretary to an eligible provider for the following  
10 items and services if medically necessary or appropriate  
11 for the maintenance of health or for the diagnosis, treat-  
12 ment, or rehabilitation of a health condition:

13 (1) Hospital services, including inpatient and  
14 outpatient hospital care, including 24-hour-a-day  
15 emergency services and inpatient prescription drugs.

16 (2) Ambulatory patient services.

17 (3) Primary and preventive services, including  
18 chronic disease management.

19 (4) Prescription drugs and medical devices, in-  
20 cluding outpatient prescription drugs, medical de-  
21 vices, and biological products.

22 (5) Mental health and substance abuse treat-  
23 ment services, including inpatient care.

24 (6) Laboratory and diagnostic services.

1           (7) Comprehensive reproductive, maternity, and  
2 newborn care.

3           (8) Pediatrics.

4           (9) Oral health, audiology, and vision services.

5           (10) Rehabilitative and habilitative services and  
6 devices.

7           (11) Emergency services and transportation.

8           (12) Early and periodic screening, diagnostic,  
9 and treatment services, as described in sections  
10 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and  
11 1905(r) of the Social Security Act (42 U.S.C.  
12 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B);  
13 1396d(r)).

14           (13) Necessary transportation to receive health  
15 care services for persons with disabilities or low-in-  
16 come individuals (as determined by the Secretary).

17           (14) Long-term care services and support (as  
18 described in section 204).

19       (b) REVISION AND ADJUSTMENT.—The Secretary  
20 shall, at least annually, and on a regular basis, evaluate  
21 whether the benefits package should be improved or ad-  
22 justed to promote the health of beneficiaries, account for  
23 changes in medical practice or new information from med-  
24 ical research, or respond to other relevant developments  
25 in health science, and shall make recommendations to

1 Congress regarding any such improvements or adjust-  
2 ments.

3 (c) HEARINGS.—

4 (1) IN GENERAL.—The Committee on Energy  
5 and Commerce and the Committee on Ways and  
6 Means of the House of Representatives shall, not  
7 less frequently than annually, hold a hearing on the  
8 recommendations submitted by the Secretary under  
9 subsection (b).

10 (2) EXERCISE OF RULEMAKING AUTHORITY.—

11 Paragraph (1) is enacted—

12 (A) as an exercise of rulemaking power of  
13 the House of Representatives, and, as such,  
14 shall be considered as part of the rules of the  
15 House, and such rules shall supersede any other  
16 rule of the House only to the extent that rule  
17 is inconsistent therewith; and

18 (B) with full recognition of the constitu-  
19 tional right of either House to change such  
20 rules (so far as relating to the procedure in  
21 such House) at any time, in the same manner,  
22 and to the same extent as in the case of any  
23 other rule of the House.

24 (d) COMPLEMENTARY AND INTEGRATIVE MEDI-  
25 CINE.—

1           (1) IN GENERAL.—In carrying out subsection  
2 (b), the Secretary shall consult with the persons de-  
3 scribed in paragraph (2) with respect to—

4                   (A) identifying specific complementary and  
5 integrative medicine practices that are appro-  
6 priate to include in the benefits package; and

7                   (B) identifying barriers to the effective  
8 provision and integration of such practices into  
9 the delivery of health care, and identifying  
10 mechanisms for overcoming such barriers.

11           (2) CONSULTATION.—In accordance with para-  
12 graph (1), the Secretary shall consult with—

13                   (A) the Director of the National Center for  
14 Complementary and Integrative Health;

15                   (B) the Commissioner of Food and Drugs;

16                   (C) institutions of higher education, pri-  
17 vate research institutes, and individual re-  
18 searchers with extensive experience in com-  
19 plementary and alternative medicine and the in-  
20 tegration of such practices into the delivery of  
21 health care;

22                   (D) nationally recognized providers of com-  
23 plementary and integrative medicine; and

24                   (E) such other officials, entities, and indi-  
25 viduals with expertise on complementary and

1 integrative medicine as the Secretary deter-  
2 mines appropriate.

3 (e) STATES MAY PROVIDE ADDITIONAL BENE-  
4 FITS.—Individual States may provide additional benefits  
5 for the residents of such States, as determined by such  
6 State, and may provide benefits to individuals not eligible  
7 for benefits under this Act, at the expense of the State,  
8 subject to the requirements specified in section 1102.

9 **SEC. 202. NO COST-SHARING.**

10 (a) IN GENERAL.—The Secretary shall ensure that  
11 no cost-sharing, including deductibles, coinsurance, copay-  
12 ments, or similar charges, is imposed on an individual for  
13 any benefits provided under this Act.

14 (b) NO BALANCE BILLING.—No provider may impose  
15 a charge to an enrolled individual for covered services for  
16 which benefits are provided under this Act.

17 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

18 (a) IN GENERAL.—Benefits for items and services  
19 are not available under this Act unless the items and serv-  
20 ices meet the standards developed by the Secretary pursu-  
21 ant to section 201(a).

22 (b) TREATMENT OF EXPERIMENTAL ITEMS AND  
23 SERVICES AND DRUGS.—

24 (1) IN GENERAL.—In applying subsection (a),  
25 the Secretary shall make national coverage deter-

1       minations with respect to items and services that are  
2       experimental in nature. Such determinations shall be  
3       consistent with the national coverage determination  
4       process as defined in section 1869(f)(1)(B) of the  
5       Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

6               (2) APPEALS PROCESS.—The Secretary shall  
7       establish a process by which individuals can appeal  
8       coverage decisions. The process shall, as much as is  
9       feasible, follow the process for appeals under the  
10       Medicare program described in section 1869 of the  
11       Social Security Act (42 U.S.C. 1395ff).

12       (c) APPLICATION OF PRACTICE GUIDELINES.—

13               (1) IN GENERAL.—In the case of items and  
14       services for which the Department of Health and  
15       Human Services has recognized a national practice  
16       guideline, such items and services shall be deemed to  
17       meet the standards specified in section 201(a) if  
18       they have been provided in accordance with such  
19       guideline. For purposes of this subsection, an item  
20       or service not provided in accordance with a practice  
21       guideline shall be deemed to have been provided in  
22       accordance with the guideline if the health care pro-  
23       vider providing the item or service—

24                       (A) exercised appropriate professional  
25                       judgment in accordance with the laws and re-

1            requirements of the State in which such item or  
2            service is furnished in deviating from the guide-  
3            line;

4            (B) acted in the best interest of the indi-  
5            vidual receiving the item or service; and

6            (C) acted in a manner consistent with the  
7            individual's wishes.

8            (2) OVERRIDE OF STANDARDS.—

9            (A) IN GENERAL.—An individual's treating  
10           physician or other health care professional au-  
11           thorized to exercise independent professional  
12           judgment in implementing a patient's medical  
13           or nursing care plan in accordance with the  
14           scope of practice, licensure, and other law of  
15           the State where items and services are to be  
16           furnished may override practice standards es-  
17           tablished pursuant to section 201(a) or practice  
18           guidelines described in paragraph (1), including  
19           such standards and guidelines that are imple-  
20           mented by a provider through the use of health  
21           information technology, such as electronic  
22           health record technology, clinical decision sup-  
23           port technology, and computerized order entry  
24           programs.



1 (B) LIMITATION.—An override described  
2 in subparagraph (A) shall, in the professional  
3 judgment of such physician, nurse, or health  
4 care professional, be—

5 (i) consistent with such physician’s,  
6 nurse’s, or health care professional’s deter-  
7 mination of medical necessity and appro-  
8 priateness or nursing assessment;

9 (ii) in the best interests of the indi-  
10 vidual; and

11 (iii) consistent with the individual’s  
12 wishes.

13 **SEC. 204. COVERAGE OF LONG-TERM CARE SERVICES.**

14 (a) IN GENERAL.—Subject to the other provisions of  
15 this Act, individuals enrolled for benefits under this Act  
16 are entitled to the following long-term services and sup-  
17 ports and to have payment made by the Secretary to an  
18 eligible provider for such services and supports if medically  
19 necessary and appropriate and in accordance with the  
20 standards established in this Act, for maintenance of  
21 health or for care, services, diagnosis, treatment, or reha-  
22 bilitation that is related to a medically determinable condi-  
23 tion, whether physical or mental, of health, injury, or age  
24 that—

1           (1) causes a functional limitation in performing  
2 one or more activities of daily living; or

3           (2) requires a similar need of assistance in per-  
4 forming instrumental activities of daily living due to  
5 cognitive or other impairments.

6           (b) ELIGIBILITY.—The Secretary shall promulgate  
7 rules that provide for the following:

8           (1) The determination of individual eligibility  
9 for long-term services and supports under this sec-  
10 tion.

11           (2) The assessment of the long-term services  
12 and supports needed for eligible individuals.

13           (c) SERVICES AND SUPPORTS.—Long-term services  
14 and supports under this section shall be tailored to an in-  
15 dividual’s needs, as determined through assessment, and  
16 shall be defined by the Secretary to—

17           (1) include any long-term nursing services for  
18 the enrollee, whether provided in an institution or in  
19 a home and community-based setting;

20           (2) provide coverage for a broad spectrum of  
21 long-term services and supports, including for home  
22 and community-based services and other care pro-  
23 vided through non-institutional settings;

24           (3) provide coverage that meets the physical,  
25 mental, and social needs of recipients while allowing

1 recipients their maximum possible autonomy and  
2 their maximum possible civic, social, and economic  
3 participation;

4 (4) prioritize delivery of long-term services and  
5 supports through home and community-based serv-  
6 ices over institutionalization;

7 (5) unless an individual elects otherwise, ensure  
8 that recipients will receive home and community  
9 based long-term services and supports (as defined in  
10 subsection (f)(4)), regardless of the individuals's  
11 type or level of disability, service need, or age;

12 (6) be provided with the goal of enabling per-  
13 sons with disabilities to receive services in the least  
14 restrictive and most integrated setting appropriate  
15 to the individual's needs;

16 (7) be provided in such a manner that allows  
17 persons with disabilities to maintain their independ-  
18 ence, self-determination, and dignity;

19 (8) provide long-term services and supports  
20 that are of equal quality and equally accessible  
21 across geographic regions; and

22 (9) ensure that long-term services and supports  
23 provide recipient's the option of self-direction of  
24 services from either the recipient or care coordina-  
25 tors of the recipient's choosing.

1 (d) PUBLIC CONSULTATION.—In developing regula-  
2 tions to implement this section, the Secretary shall consult  
3 with an advisory commission on long-term services and  
4 supports that includes—

5 (1) people with disabilities who use long-term  
6 services and supports and older adults who use long-  
7 term services and supports;

8 (2) representatives of people with disabilities  
9 and representatives of older adults;

10 (3) groups that represent the diversity of the  
11 population of people living with disabilities, including  
12 gender, racial, and economic diversity;

13 (4) providers of long-term services and sup-  
14 ports, including family attendants and family care-  
15 givers, and members of organized labor;

16 (5) disability rights organizations; and

17 (6) relevant academic institutions and research-  
18 ers.

19 (e) BUDGETING AND PAYMENTS.—Budgeting and  
20 payments for long-term services and supports provided  
21 under this section shall be made in accordance with the  
22 provisions under title VI.

23 (f) DEFINITIONS.—In this section:

24 (1) The term “long-term services and supports”  
25 means long-term care, treatment, maintenance, or

1 services needed to support the activities of daily liv-  
2 ing and instrumental activities of daily living, includ-  
3 ing all long-term services and supports available  
4 under section 1915 of the Social Security Act (42  
5 U.S.C. 1396n), home and community-based services,  
6 and any additional services and supports identified  
7 by the Secretary to support people with disabilities  
8 to live, work, and participate in their communities.

9 (2) The term “activities of daily living” means  
10 basic personal everyday activities, including tasks  
11 such as eating, toileting, grooming, dressing, bath-  
12 ing, and transferring.

13 (3) The term “instrumental activities of daily  
14 living” means activities related to living independ-  
15 ently in the community, including but not limited to,  
16 meal planning and preparation, managing finances,  
17 shopping for food, clothing, and other essential  
18 items, performing essential household chores, com-  
19 municating by phone or other media, and traveling  
20 around and participating in the community.

21 (4) The term “home and community-based  
22 services” means the home and community-based  
23 services that are coverable under subsections (c),  
24 (d), (i), and (k) of section 1915 of the Social Secu-  
25 rity Act (42 U.S.C. 1396n), and as defined by the

1 Secretary, including as defined in the home and  
2 community-based services settings rule in sections  
3 441.530 and 441.710 of title 42, Code of Federal  
4 Regulations (or a successor regulation).

5 **TITLE III—PROVIDER**  
6 **PARTICIPATION**

7 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS;**  
8 **WHISTLEBLOWER PROTECTIONS.**

9 (a) IN GENERAL.—An individual or other entity fur-  
10 nishing any covered item or service under this Act is not  
11 a qualified provider unless the individual or entity—

12 (1) is a qualified provider of the items or serv-  
13 ices under section 302;

14 (2) has filed with the Secretary a participation  
15 agreement described in subsection (b); and

16 (3) meets, as applicable, such other qualifica-  
17 tions and conditions with respect to a provider of  
18 services under title XVIII of the Social Security Act  
19 as described in section 1866 of the Social Security  
20 Act (42 U.S.C. 1395cc).

21 (b) REQUIREMENTS IN PARTICIPATION AGREE-  
22 MENT.—

23 (1) IN GENERAL.—A participation agreement  
24 described in this subsection between the Secretary

1 and a provider shall provide at least for the fol-  
2 lowing:

3 (A) Items and services to eligible persons  
4 shall be furnished by the provider without dis-  
5 crimination, in accordance with section 104(a).  
6 Nothing in this subparagraph shall be con-  
7 strued as requiring the provision of a type or  
8 class of items or services that are outside the  
9 scope of the provider's normal practice.

10 (B) No charge will be made to any enrolled  
11 individual for any covered items or services  
12 other than for payment authorized by this Act.

13 (C) The provider agrees to furnish such in-  
14 formation as may be reasonably required by the  
15 Secretary, in accordance with uniform reporting  
16 standards established under section 401(b)(1),  
17 for—

18 (i) quality review by designated enti-  
19 ties;

20 (ii) making payments under this Act,  
21 including the examination of records as  
22 may be necessary for the verification of in-  
23 formation on which such payments are  
24 based;

1 (iii) statistical or other studies re-  
2 quired for the implementation of this Act;  
3 and

4 (iv) such other purposes as the Sec-  
5 retary may specify.

6 (D) In the case of a provider that is not  
7 an individual, the provider agrees not to employ  
8 or use for the provision of health services any  
9 individual or other provider that has had a par-  
10 ticipation agreement under this subsection ter-  
11 minated for cause. The Secretary may authorize  
12 such employment or use on a case-by-case  
13 basis.

14 (E) In the case of a provider paid under  
15 a fee-for-service basis for items and services  
16 furnished under this Act, the provider agrees to  
17 submit bills and any required supporting docu-  
18 mentation relating to the provision of covered  
19 items and services within 30 days after the date  
20 of providing such items and services.

21 (F) In the case of an institutional provider  
22 paid pursuant to section 611, the provider  
23 agrees to submit information and any other re-  
24 quired supporting documentation as may be  
25 reasonably required by the Secretary within 30



1 days after the date of providing such items and  
2 services and in accordance with the uniform re-  
3 porting standards established under section  
4 401(b)(1), including information on a quarterly  
5 basis that—

6 (i) relates to the provision of covered  
7 items and services; and

8 (ii) describes items and services fur-  
9 nished with respect to specific individuals.

10 (G) In the case of a provider that receives  
11 payment for items and services furnished under  
12 this Act based on diagnosis-related coding, pro-  
13 cedure coding, or other coding system or data,  
14 the provider agrees—

15 (i) to disclose to the Secretary any  
16 system or index of coding or classifying pa-  
17 tient symptoms, diagnoses, clinical inter-  
18 ventions, episodes, or procedures that such  
19 provider utilizes for global budget negotia-  
20 tions under title VI or for meeting any  
21 other payment, documentation, or data col-  
22 lection requirements under this Act; and

23 (ii) not to use any such system or  
24 index to establish financial incentives or  
25 disincentives for health care professionals,

1 or that is proprietary, interferes with the  
2 medical or nursing process, or is designed  
3 to increase the amount or number of pay-  
4 ments.

5 (H) The provider complies with the duty of  
6 provider ethics and reporting requirements de-  
7 scribed in paragraph (2).

8 (I) In the case of a provider that is not an  
9 individual, the provider agrees that no board  
10 member, executive, or administrator of such  
11 provider receives compensation from, owns  
12 stock or has other financial investments in, or  
13 serves as a board member of any entity that  
14 contracts with or provides items or services, in-  
15 cluding pharmaceutical products and medical  
16 devices or equipment, to such provider.

17 (2) PROVIDER DUTY OF ETHICS.—Each health  
18 care provider, including institutional providers, has a  
19 duty to advocate for and to act in the exclusive in-  
20 terest of each individual under the care of such pro-  
21 vider according to the applicable legal standard of  
22 care, such that no financial interest or relationship  
23 impairs any health care provider’s ability to furnish  
24 necessary and appropriate care to such individual.

1 To implement the duty established in this para-  
2 graph, the Secretary shall—

3 (A) promulgate reasonable reporting rules  
4 to evaluate participating provider compliance  
5 with this paragraph;

6 (B) prohibit participating providers,  
7 spouses, and immediate family members of par-  
8 ticipating providers, from accepting or entering  
9 into any arrangement for any bonus, incentive  
10 payment, profit-sharing, or compensation based  
11 on patient utilization or based on financial out-  
12 comes of any other provider or entity; and

13 (C) prohibit participating providers or any  
14 board member or representative of such pro-  
15 vider from serving as board members for or re-  
16 ceiving any compensation, stock, or other finan-  
17 cial investment in an entity that contracts with  
18 or provides items or services (including pharma-  
19 ceutical products and medical devices or equip-  
20 ment) to such provider.

21 (3) TERMINATION OF PARTICIPATION AGREE-  
22 MENT.—

23 (A) IN GENERAL.—Participation agree-  
24 ments may be terminated, with appropriate no-  
25 tice—

1 (i) by the Secretary for failure to meet  
2 the requirements of this Act;

3 (ii) in accordance with the provisions  
4 described in section 411; or

5 (iii) by a provider.

6 (B) TERMINATION PROCESS.—Providers  
7 shall be provided notice and a reasonable oppor-  
8 tunity to correct deficiencies before the Sec-  
9 retary terminates an agreement unless a more  
10 immediate termination is required for public  
11 safety or similar reasons.

12 (C) PROVIDER PROTECTIONS.—

13 (i) PROHIBITION.—The Secretary may  
14 not terminate a participation agreement or  
15 in any other way discriminate against, or  
16 cause to be discriminated against, any cov-  
17 ered provider or authorized representative  
18 of the provider, on account of such pro-  
19 vider or representative—

20 (I) providing, causing to be pro-  
21 vided, or being about to provide or  
22 cause to be provided to the provider,  
23 the Federal Government, or the attor-  
24 ney general of a State information re-  
25 lating to any violation of, or any act

1 or omission the provider or represent-  
2 ative reasonably believes to be a viola-  
3 tion of, any provision of this title (or  
4 an amendment made by this title);

5 (II) testifying or being about to  
6 testify in a proceeding concerning  
7 such violation;

8 (III) assisting or participating, or  
9 being about to assist or participate, in  
10 such a proceeding; or

11 (IV) objecting to, or refusing to  
12 participate in, any activity, policy,  
13 practice, or assigned task that the  
14 provider or representative reasonably  
15 believes to be in violation of any provi-  
16 sion of this Act (including any amend-  
17 ment made by this Act), or any order,  
18 rule, regulation, standard, or ban  
19 under this Act (including any amend-  
20 ment made by this Act).

21 (ii) COMPLAINT PROCEDURE.—A pro-  
22 vider or representative who believes that he  
23 or she has been discriminated against in  
24 violation of this section may seek relief in  
25 accordance with the procedures, notifica-

1                   tions, burdens of proof, remedies, and stat-  
2                   utes of limitation set forth in section  
3                   2087(b) of title 15, United States Code.

4           (c) WHISTLEBLOWER PROTECTIONS.—

5                   (1) RETALIATION PROHIBITED.—No person  
6                   may discharge or otherwise discriminate against any  
7                   employee because the employee or any person acting  
8                   pursuant to a request of the employee—

9                           (A) notified the Secretary or the employ-  
10                           ee’s employer of any alleged violation of this  
11                           title, including communications related to car-  
12                           rying out the employee’s job duties;

13                           (B) refused to engage in any practice made  
14                           unlawful by this title, if the employee has iden-  
15                           tified the alleged illegality to the employer;

16                           (C) testified before or otherwise provided  
17                           information relevant for Congress or for any  
18                           Federal or State proceeding regarding any pro-  
19                           vision (or proposed provision) of this title;

20                           (D) commenced, caused to be commenced,  
21                           or is about to commence or cause to be com-  
22                           menced a proceeding under this title;

23                           (E) testified or is about to testify in any  
24                           such proceeding; or

1 (F) assisted or participated or is about to  
2 assist or participate in any manner in such a  
3 proceeding or in any other manner in such a  
4 proceeding or in any other action to carry out  
5 the purposes of this title.

6 (2) ENFORCEMENT ACTION.—Any employee  
7 covered by this section who alleges discrimination by  
8 an employer in violation of paragraph (1) may bring  
9 an action, subject to the statute of limitations in the  
10 anti-retaliation provisions of the False Claims Act  
11 and the rules and procedures, legal burdens of proof,  
12 and remedies applicable under the employee protec-  
13 tions provisions of the Surface Transportation As-  
14 sistance Act.

15 (3) APPLICATION.—

16 (A) Nothing in this subsection shall be  
17 construed to diminish the rights, privileges, or  
18 remedies of any employee under any Federal or  
19 State law or regulation, including the rights  
20 and remedies against retaliatory action under  
21 the False Claims Act (31 U.S.C. 3730(h)), or  
22 under any collective bargaining agreement. The  
23 rights and remedies in this section may not be  
24 waived by any agreement, policy, form, or con-  
25 dition of employment.

1           (B) Nothing in this subsection shall be  
2 construed to preempt or diminish any other  
3 Federal or State law or regulation against dis-  
4 crimination, demotion, discharge, suspension,  
5 threats, harassment, reprimand, retaliation, or  
6 any other manner of discrimination, including  
7 the rights and remedies against retaliatory ac-  
8 tion under the False Claims Act (31 U.S.C.  
9 3730(h)).

10       (4) DEFINITIONS.—In this subsection:

11           (A) EMPLOYER.—The term “employer”  
12 means any person engaged in profit or non-  
13 profit business or industry, including one or  
14 more individuals, partnerships, associations,  
15 corporations, trusts, professional membership  
16 organization including a certification, discipli-  
17 nary, or other professional body, unincorporated  
18 organizations, nongovernmental organizations,  
19 or trustees, and subject to liability for violating  
20 the provisions of this Act.

21           (B) EMPLOYEE.—The term “employee”  
22 means any individual performing activities  
23 under this Act on behalf of an employer.



1 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

2 (a) IN GENERAL.—A health care provider is consid-  
3 ered to be qualified to furnish covered items and services  
4 under this Act if the provider is licensed or certified to  
5 furnish such items and services in the State in which such  
6 items or services are furnished and meets—

7 (1) the requirements of such State’s law to fur-  
8 nish such items and services; and

9 (2) applicable requirements of Federal law to  
10 furnish such items and services.

11 (b) LIMITATION.—An entity or provider shall not be  
12 qualified to furnish covered items and services under this  
13 Act if the entity or provider provides no items and services  
14 directly to individuals, including—

15 (1) entities or providers that contract with  
16 other entities or providers to provide such items and  
17 services; and

18 (2) entities that are currently approved to co-  
19 ordinate care plans under the Medicare Advantage  
20 program established in part C of title XVIII of the  
21 Social Security Act (42 U.S.C. 1851 et seq.) but do  
22 not directly provide items and services of such care  
23 plans.

24 (c) MINIMUM PROVIDER STANDARDS.—

25 (1) IN GENERAL.—The Secretary shall estab-  
26 lish, evaluate, and update national minimum stand-

1 ards to ensure the quality of items and services pro-  
2 vided under this Act and to monitor efforts by  
3 States to ensure the quality of such items and serv-  
4 ices. A State may establish additional minimum  
5 standards which providers shall meet with respect to  
6 items and services provided in such State.

7 (2) NATIONAL MINIMUM STANDARDS.—The  
8 Secretary shall establish national minimum stand-  
9 ards under paragraph (1) for institutional providers  
10 of services and individual health care practitioners.  
11 Except as the Secretary may specify in order to  
12 carry out this Act, a hospital, skilled nursing facility,  
13 or other institutional provider of services shall meet  
14 standards applicable to such a provider under the  
15 Medicare program under title XVIII of the Social  
16 Security Act (42 U.S.C. 1395 et seq.). Such stand-  
17 ards also may include, where appropriate, elements  
18 relating to—

19 (A) adequacy and quality of facilities;

20 (B) mandatory minimum safe registered  
21 nurse-to-patient staffing ratios and optimal  
22 staffing levels for physicians and other health  
23 care practitioners;

24 (C) training and competence of personnel  
25 (including requirements related to the number

1 of or type of required continuing education  
2 hours);

3 (D) comprehensiveness of service;

4 (E) continuity of service;

5 (F) patient waiting time, access to serv-  
6 ices, and preferences; and

7 (G) performance standards, including orga-  
8 nization, facilities, structure of services, effi-  
9 ciency of operation, and outcome in palliation,  
10 improvement of health, stabilization, cure, or  
11 rehabilitation.

12 (3) TRANSITION IN APPLICATION.—If the Sec-  
13 retary provides for additional requirements for pro-  
14 viders under this subsection, any such additional re-  
15 quirement shall be implemented in a manner that  
16 provides for a reasonable period during which a pre-  
17 viously qualified provider is permitted to meet such  
18 an additional requirement.

19 (4) ABILITY TO PROVIDE SERVICES.—With re-  
20 spect to any entity or provider certified to provide  
21 items and services described in section 201(a)(7),  
22 the Secretary may not prohibit such entity or pro-  
23 vider from participating for reasons other than such  
24 entity's or provider's ability to provide such items  
25 and services.

1 (d) FEDERAL PROVIDERS.—Any provider qualified to  
2 provide health care items and services through the Depart-  
3 ment of Veterans Affairs or Indian Health Service is a  
4 qualifying provider under this section with respect to any  
5 individual who qualifies for such items and services under  
6 applicable Federal law.

7 **SEC. 303. USE OF PRIVATE CONTRACTS.**

8 (a) IN GENERAL.—This section shall apply beginning  
9 2 years after the date of the enactment of this Act.

10 (b) PARTICIPATING PROVIDERS.—

11 (1) PRIVATE CONTRACTS FOR COVERED ITEMS  
12 AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-  
13 stitutional or individual provider with an agreement  
14 in effect under section 301 may not bill or enter into  
15 any private contract with any individual eligible for  
16 benefits under the Act for any item or service that  
17 is a benefit under this Act.

18 (2) PRIVATE CONTRACTS FOR NONCOVERED  
19 ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—  
20 An institutional or individual provider with an agree-  
21 ment in effect under section 301 may bill or enter  
22 into a private contract with an individual eligible for  
23 benefits under the Act for any item or service that  
24 is not a benefit under this Act only if—

1 (A) the contract and provider meet the re-  
2 quirements specified in paragraphs (3) and (4),  
3 respectively;

4 (B) such item or service is not payable or  
5 available under this Act; and

6 (C) the provider receives—

7 (i) no reimbursement under this Act  
8 directly or indirectly for such item or serv-  
9 ice, and

10 (ii) receives no amount for such item  
11 or service from an organization which re-  
12 ceives reimbursement for such items or  
13 service under this Act directly or indirectly.

14 (3) CONTRACT REQUIREMENTS.—Any contract  
15 to provide items and services described in paragraph  
16 (2) shall—

17 (A) be in writing and signed by the indi-  
18 vidual (or authorized representative of the indi-  
19 vidual) receiving the item or service before the  
20 item or service is furnished pursuant to the  
21 contract;

22 (B) not be entered into at a time when the  
23 individual is facing an emergency health care  
24 situation; and

1 (C) clearly indicate to the individual receiv-  
2 ing such items and services that by signing  
3 such a contract the individual—

4 (i) agrees not to submit a claim (or to  
5 request that the provider submit a claim)  
6 under this Act for such items or services;

7 (ii) agrees to be responsible for pay-  
8 ment of such items or services and under-  
9 stands that no reimbursement will be pro-  
10 vided under this Act for such items or  
11 services;

12 (iii) acknowledges that no limits under  
13 this Act apply to amounts that may be  
14 charged for such items or services; and

15 (iv) acknowledges that the provider is  
16 providing services outside the scope of the  
17 program under this Act.

18 (4) AFFIDAVIT.—A participating provider who  
19 enters into a contract described in paragraph (2)  
20 shall have in effect during the period any item or  
21 service is to be provided pursuant to the contract an  
22 affidavit that shall—

23 (A) identify the provider who is to furnish  
24 such noncovered item or service, and be signed  
25 by such provider;

1 (B) state that the provider will not submit  
2 any claim under this Act for any noncovered  
3 item or service provided to any individual en-  
4 rolled under this Act; and

5 (C) be filed with the Secretary no later  
6 than 10 days after the first contract to which  
7 such affidavit applies is entered into.

8 (5) ENFORCEMENT.—If a provider signing an  
9 affidavit described in paragraph (4) knowingly and  
10 willfully submits a claim under this title for any item  
11 or service provided or receives any reimbursement or  
12 amount for any such item or service provided pursu-  
13 ant to a private contract described in paragraph (2)  
14 with respect to such affidavit—

15 (A) any contract described in paragraph  
16 (2) shall be null and void;

17 (B) no payment shall be made under this  
18 title for any item or service furnished by the  
19 provider during the 1-year period beginning on  
20 the date the affidavit was signed; and

21 (C) any payment received under this title  
22 for any item or service furnished during such  
23 period shall be remitted.

24 (6) PRIVATE CONTRACTS FOR INELIGIBLE INDI-  
25 VIDUALS.—An institutional or individual provider

1 with an agreement in effect under section 301 may  
2 bill or enter into a private contract with any indi-  
3 vidual ineligible for benefits under the Act for any  
4 item or service.

5 (c) NONPARTICIPATING PROVIDERS.—

6 (1) PRIVATE CONTRACTS FOR COVERED ITEMS  
7 AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-  
8 stitutional or individual provider with no agreement  
9 in effect under section 301 may bill or enter into  
10 any private contract with any individual eligible for  
11 benefits under the Act for any item or service that  
12 is a benefit under this Act described in title II only  
13 if the contract and provider meet the requirements  
14 specified in paragraphs (2) and (3), respectively.

15 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-  
16 TRACT.—Any contract to provide items and services  
17 described in paragraph (1) shall—

18 (A) be in writing and signed by the indi-  
19 vidual (or authorized representative of the indi-  
20 vidual) receiving the item or service before the  
21 item or service is furnished pursuant to the  
22 contract;

23 (B) not be entered into at a time when the  
24 individual is facing an emergency health care  
25 situation; and



1 (C) clearly indicate to the individual receiv-  
2 ing such items and services that by signing  
3 such a contract the individual—

4 (i) acknowledges that the individual  
5 has the right to have such items or services  
6 provided by other providers for whom pay-  
7 ment would be made under this Act;

8 (ii) agrees not to submit a claim (or  
9 to request that the provider submit a  
10 claim) under this Act for such items or  
11 services even if such items or services are  
12 otherwise covered by this Act;

13 (iii) agrees to be responsible for pay-  
14 ment of such items or services and under-  
15 stands that no reimbursement will be pro-  
16 vided under this Act for such items or  
17 services;

18 (iv) acknowledges that no limits under  
19 this Act apply to amounts that may be  
20 charged for such items or services; and

21 (v) acknowledges that the provider is  
22 providing services outside the scope of the  
23 program under this Act.

24 (3) AFFIDAVIT.—A provider who enters into a  
25 contract described in paragraph (1) shall have in ef-

1       fect during the period any item or service is to be  
2       provided pursuant to the contract an affidavit that  
3       shall—

4               (A) identify the provider who is to furnish  
5       such covered item or service, and be signed by  
6       such provider;

7               (B) state that the provider will not submit  
8       any claim under this Act for any covered item  
9       or service provided to any individual enrolled  
10      under this Act during the 2-year period begin-  
11      ning on the date the affidavit is signed; and

12              (C) be filed with the Secretary no later  
13      than 10 days after the first contract to which  
14      such affidavit applies is entered into.

15              (4) ENFORCEMENT.—If a provider signing an  
16      affidavit described in paragraph (3) knowingly and  
17      willfully submits a claim under this title for any item  
18      or service provided or receives any reimbursement or  
19      amount for any such item or service provided pursu-  
20      ant to a private contract described in paragraph (1)  
21      with respect to such affidavit—

22              (A) any contract described in paragraph  
23      (1) shall be null and void; and

24              (B) no payment shall be made under this  
25      title for any item or service furnished by the

1 provider during the 2-year period beginning on  
2 the date the affidavit was signed.

3 (5) PRIVATE CONTRACTS FOR NONCOVERED  
4 ITEMS AND SERVICES FOR ANY INDIVIDUAL.—An in-  
5 stitutional or individual provider with no agreement  
6 in effect under section 301 may bill or enter into a  
7 private contract with any individual for a item or  
8 service that is not a benefit under this Act.

## 9 **TITLE IV—ADMINISTRATION**

### 10 **Subtitle A—General**

### 11 **Administration Provisions**

#### 12 **SEC. 401. ADMINISTRATION.**

13 (a) GENERAL DUTIES OF THE SECRETARY.—

14 (1) IN GENERAL.—The Secretary shall develop  
15 policies, procedures, guidelines, and requirements to  
16 carry out this Act, including related to—

17 (A) eligibility for benefits;

18 (B) enrollment;

19 (C) benefits provided;

20 (D) provider participation standards and  
21 qualifications, as described in title III;

22 (E) levels of funding;

23 (F) methods for determining amounts of  
24 payments to providers of covered items and  
25 services, consistent with subtitle B;

1 (G) a process for appealing or petitioning  
2 for a determination of coverage or noncoverage  
3 of items and services under this Act;

4 (H) planning for capital expenditures and  
5 service delivery;

6 (I) planning for health professional edu-  
7 cation funding;

8 (J) encouraging States to develop regional  
9 planning mechanisms; and

10 (K) any other regulations necessary to  
11 carry out the purposes of this Act.

12 (2) REGULATIONS.—Regulations authorized by  
13 this Act shall be issued by the Secretary in accord-  
14 ance with section 553 of title 5, United States Code.

15 (3) ACCESSIBILITY.—The Secretary shall have  
16 the obligation to ensure the timely and accessible  
17 provision of items and services that all eligible indi-  
18 viduals are entitled to under this Act.

19 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-  
20 PORT; STUDIES.—

21 (1) UNIFORM REPORTING STANDARDS.—

22 (A) IN GENERAL.—The Secretary shall es-  
23 tablish uniform State reporting requirements  
24 and national standards to ensure an adequate  
25 national database containing information per-

1           taining to health services practitioners, ap-  
2           proved providers, the costs of facilities and  
3           practitioners providing items and services, the  
4           quality of such items and services, the outcomes  
5           of such items and services, and the equity of  
6           health among population groups. Such database  
7           shall include, to the maximum extent feasible  
8           without compromising patient privacy, health  
9           outcome measures used under this Act, and to  
10          the maximum extent feasible without excessively  
11          burdening providers, a description of the stand-  
12          ards and qualifications, levels of finding, and  
13          methods described in subparagraphs (D)  
14          through (F) of subsection (a)(1).

15                (B) REQUIRED DATA DISCLOSURES.—In  
16                establishing reporting requirements and stand-  
17                ards under subparagraph (A), the Secretary  
18                shall require a provider with an agreement in  
19                effect under section 301 to disclose to the Sec-  
20                retary, in a time and manner specified by the  
21                Secretary, the following (as applicable to the  
22                type of provider):

23                       (i) Any data the provider is required  
24                       to report or does report to any State or  
25                       local agency, or, as of January 1, 2019, to

1 the Secretary or any entity that is part of  
2 the Department of Health and Human  
3 Services, except data that are required  
4 under the programs terminated in section  
5 903.

6 (ii) Annual financial data that in-  
7 cludes information on employees (including  
8 the number of employees, hours worked,  
9 and wage information) by job title and by  
10 each patient care unit or department with-  
11 in each facility (including outpatient units  
12 or departments); the number of registered  
13 nurses per staffed bed by each such unit or  
14 department; information on the dollar  
15 value and annual spending (including pur-  
16 chases, upgrades, and maintenance) for  
17 health information technology; and risk-ad-  
18 justed and raw patient outcome data (in-  
19 cluding data on medical, surgical, obstet-  
20 ric, and other procedures).

21 (C) REPORTS.—The Secretary shall regu-  
22 larly analyze information reported to the Sec-  
23 retary and shall define rules and procedures to  
24 allow researchers, scholars, health care pro-  
25 viders, and others to access and analyze data

1 for purposes consistent with quality and out-  
2 comes research, without compromising patient  
3 privacy.

4 (2) ANNUAL REPORT.—Beginning 2 years after  
5 the date of the enactment of this Act, the Secretary  
6 shall annually report to Congress on the following:

7 (A) The status of implementation of the  
8 Act.

9 (B) Enrollment under this Act.

10 (C) Benefits under this Act.

11 (D) Expenditures and financing under this  
12 Act.

13 (E) Cost-containment measures and  
14 achievements under this Act.

15 (F) Quality assurance.

16 (G) Health care utilization patterns, in-  
17 cluding any changes attributable to the pro-  
18 gram.

19 (H) Changes in the per-capita costs of  
20 health care.

21 (I) Differences in the health status of the  
22 populations of the different States, including in-  
23 come and racial characteristics, and other popu-  
24 lation health inequities.

1           (J) Progress on quality and outcome meas-  
2           ures, and long-range plans and goals for  
3           achievements in such areas.

4           (K) Plans for improving service to medi-  
5           cally underserved populations.

6           (L) Transition problems as a result of im-  
7           plementation of this Act.

8           (M) Opportunities for improvements under  
9           this Act.

10          (3) STATISTICAL ANALYSES AND OTHER STUD-  
11          IES.—The Secretary may, either directly or by con-  
12          tract—

13               (A) make statistical and other studies, on  
14               a nationwide, regional, State, or local basis, of  
15               any aspect of the operation of this Act;

16               (B) develop and test methods of delivery of  
17               items and services as the Secretary may con-  
18               sider necessary or promising for the evaluation,  
19               or for the improvement, of the operation of this  
20               Act; and

21               (C) develop methodological standards for  
22               policymaking.

23          (e) AUDITS.—

24               (1) IN GENERAL.—The Comptroller General of  
25               the United States shall conduct an audit of the De-



1       partment of Health and Human Services every fifth  
2       fiscal year following the effective date of this Act to  
3       determine the effectiveness of the program in car-  
4       rying out the duties under subsection (a).

5               (2) REPORTS.—The Comptroller General of the  
6       United States shall submit a report to Congress con-  
7       cerning the results of each audit conducted under  
8       this subsection.

9       **SEC. 402. CONSULTATION.**

10       The Secretary shall consult with Federal agencies,  
11       Indian tribes and urban Indian health organizations, and  
12       private entities, such as labor organizations representing  
13       health care workers, professional societies, national asso-  
14       ciations, nationally recognized associations of health care  
15       experts, medical schools and academic health centers, con-  
16       sumer groups, and business organizations in the formula-  
17       tion of guidelines, regulations, policy initiatives, and infor-  
18       mation gathering to ensure the broadest and most in-  
19       formed input in the administration of this Act. Nothing  
20       in this Act shall prevent the Secretary from adopting  
21       guidelines, consistent with the provisions of section 203(e),  
22       developed by such a private entity if, in the Secretary's  
23       judgment, such guidelines are generally accepted as rea-  
24       sonable and prudent and consistent with this Act.

1 **SEC. 403. REGIONAL ADMINISTRATION.**

2 (a) COORDINATION WITH REGIONAL OFFICES.—The  
3 Secretary shall establish and maintain regional offices for  
4 purposes of carrying out the duties specified in subsection  
5 (c) and promoting adequate access to, and efficient use  
6 of, tertiary care facilities, equipment, and services by indi-  
7 viduals enrolled under this Act. Wherever possible, the  
8 Secretary shall incorporate regional offices of the Centers  
9 for Medicare & Medicaid Services for this purpose.

10 (b) APPOINTMENT OF REGIONAL DIRECTORS.—In  
11 each such regional office there shall be—

12 (1) one regional director appointed by the Sec-  
13 retary; and

14 (2) one deputy director appointed by the re-  
15 gional director to represent the Indian and Alaska  
16 Native tribes in the region, if any.

17 (c) REGIONAL OFFICE DUTIES.—Each regional di-  
18 rector shall—

19 (1) provide an annual health care needs assess-  
20 ment with respect to the region under the director's  
21 jurisdiction to the Secretary after a thorough exam-  
22 ination of health needs and in consultation with pub-  
23 lic health officials, clinicians, patients, and patient  
24 advocates;

25 (2) recommend any changes in provider reim-  
26 bursement or payment for delivery of health services

1 determined appropriate by the regional director, sub-  
2 ject to the provisions of title VI; and

3 (3) establish a quality assurance mechanism in  
4 each such region in order to minimize both under-  
5 utilization and overutilization of health care items  
6 and services and to ensure that all providers meet  
7 quality standards established pursuant to this Act.

8 **SEC. 404. BENEFICIARY OMBUDSMAN.**

9 (a) IN GENERAL.—The Secretary shall appoint a  
10 Beneficiary Ombudsman who shall have expertise and ex-  
11 perience in the fields of health care and education of, and  
12 assistance to, individuals enrolled under this Act.

13 (b) DUTIES.—The Beneficiary Ombudsman shall—

14 (1) receive complaints, grievances, and requests  
15 for information submitted by individuals enrolled  
16 under this Act or eligible to enroll under this Act  
17 with respect to any aspect of the Medicare for All  
18 Program;

19 (2) provide assistance with respect to com-  
20 plaints, grievances, and requests referred to in para-  
21 graph (1), including assistance in collecting relevant  
22 information for such individuals, to seek an appeal  
23 of a decision or determination made by a regional of-  
24 fice or the Secretary; and

1           (3) submit annual reports to Congress and the  
2           Secretary that describe the activities of the Ombuds-  
3           man and that include such recommendations for im-  
4           provement in the administration of this Act as the  
5           Ombudsman determines appropriate. The Ombuds-  
6           man shall not serve as an advocate for any increases  
7           in payments or new coverage of services, but may  
8           identify issues and problems in payment or coverage  
9           policies.

10 **SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.**

11           In performing functions with respect to health per-  
12           sonnel education and training, health research, environ-  
13           mental health, disability insurance, vocational rehabilita-  
14           tion, the regulation of food and drugs, and all other mat-  
15           ters pertaining to health, the Secretary shall direct the ac-  
16           tivities of the Department of Health and Human Services  
17           toward contributions to the health of the people com-  
18           plementary to this Act.

19           **Subtitle B—Control Over Fraud**  
20                           **and Abuse**

21 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL**  
22                           **FRAUD AND ABUSE UNDER THE MEDICARE**  
23                           **FOR ALL PROGRAM.**

24           The following sections of the Social Security Act shall  
25           apply to this Act in the same manner as they apply to

1 title XVIII or State plans under title XIX of the Social  
2 Security Act:

3 (1) Section 1128 (relating to exclusion of indi-  
4 viduals and entities).

5 (2) Section 1128A (civil monetary penalties).

6 (3) Section 1128B (criminal penalties).

7 (4) Section 1124 (relating to disclosure of own-  
8 ership and related information).

9 (5) Section 1126 (relating to disclosure of cer-  
10 tain owners).

11 (6) Section 1877 (relating to physician refer-  
12 rals).

## 13 **TITLE V—QUALITY ASSESSMENT**

### 14 **SEC. 501. QUALITY STANDARDS.**

15 (a) IN GENERAL.—All standards and quality meas-  
16 ures under this Act shall be implemented and evaluated  
17 by the Center for Clinical Standards and Quality of the  
18 Centers for Medicare & Medicaid Services (referred to in  
19 this title as the “Center”) or such other agency deter-  
20 mined appropriate by the Secretary, in coordination with  
21 the Agency for Healthcare Research and Quality and other  
22 offices of the Department of Health and Human Services.

23 (b) DUTIES OF THE CENTER.—The Center shall per-  
24 form the following duties:

1           (1) Review and evaluate each practice guideline  
2 developed under part B of title IX of the Public  
3 Health Service Act. In so reviewing and evaluating,  
4 the Center shall determine whether the guideline  
5 should be recognized as a national practice guideline  
6 in accordance with and subject to the provisions of  
7 section 203(c).

8           (2) Review and evaluate each standard of qual-  
9 ity, performance measure, and medical review cri-  
10 terion developed under part B of title IX of the Pub-  
11 lic Health Service Act (42 U.S.C. 299 et seq.). In  
12 so reviewing and evaluating, the Center shall deter-  
13 mine whether the standard, measure, or criterion is  
14 appropriate for use in assessing or reviewing the  
15 quality of items and services provided by health care  
16 institutions or health care professionals. The use of  
17 Quality-Adjusted Life Years, Disability-Adjusted  
18 Life Years, or other similar mechanisms that dis-  
19 criminate against people with disabilities is prohib-  
20 ited for use in any value or cost-effectiveness assess-  
21 ments. The Center shall consider the evidentiary  
22 basis for the standard, and the validity, reliability,  
23 and feasibility of measuring the standard.

1           (3) Adoption of methodologies for profiling the  
2 patterns of practice of health care professionals and  
3 for identifying and notifying outliers.

4           (4) Development of minimum criteria for com-  
5 petence for entities that can qualify to conduct ongo-  
6 ing and continuous external quality reviews in the  
7 administrative regions. Such criteria shall require  
8 such an entity to be administratively independent of  
9 the individual or board that administers the region  
10 and shall ensure that such entities do not provide fi-  
11 nancial incentives to reviewers to favor one pattern  
12 of practice over another. The Center shall ensure co-  
13 ordination and reporting by such entities to ensure  
14 national consistency in quality standards.

15           (5) Submission of a report to the Secretary an-  
16 nually specifically on findings from outcomes re-  
17 search and development of practice guidelines that  
18 may affect the Secretary's determination of coverage  
19 of services under section 401(a)(1)(G).

20 **SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.**

21           (a) **EVALUATING DATA COLLECTION AP-**  
22 **PROACHES.**—The Center shall evaluate approaches for the  
23 collection of data under this Act, to be performed in con-  
24 junction with existing quality reporting requirements and  
25 programs under this Act, that allow for the ongoing, accu-

1 rate, and timely collection of data on disparities in health  
2 care services and performance on the basis of race, eth-  
3 nicity, gender, geography, disability, or socioeconomic sta-  
4 tus. In conducting such evaluation, the Center shall con-  
5 sider the following objectives:

6 (1) Protecting patient privacy.

7 (2) Minimizing the administrative burdens of  
8 data collection and reporting on providers under this  
9 Act.

10 (3) Improving data on race, ethnicity, gender,  
11 geography, and socioeconomic status.

12 (b) REPORTS TO CONGRESS.—

13 (1) REPORT ON EVALUATION.—Not later than  
14 18 months after the date on which benefits first be-  
15 come available as described in section 106(a), the  
16 Center shall submit to Congress and the Secretary  
17 a report on the evaluation conducted under sub-  
18 section (a). Such report shall, taking into consider-  
19 ation the results of such evaluation—

20 (A) identify approaches (including defining  
21 methodologies) for identifying and collecting  
22 and evaluating data on health care disparities  
23 on the basis of race, ethnicity, gender, geog-  
24 raphy, or socioeconomic status under the Medi-  
25 care for All Program; and



1           (B) include recommendations on the most  
2           effective strategies and approaches to reporting  
3           quality measures, as appropriate, on the basis  
4           of race, ethnicity, gender, geography, or socio-  
5           economic status.

6           (2) REPORT ON DATA ANALYSES.—Not later  
7           than 4 years after the submission of the report  
8           under subsection (b)(1), and every 4 years there-  
9           after, the Center shall submit to Congress and the  
10          Secretary a report that includes recommendations  
11          for improving the identification of health care dis-  
12          parities based on the analyses of data collected  
13          under subsection (c).

14          (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not  
15          later than 2 years after the date on which benefits first  
16          become available as described in section 106(a), the Sec-  
17          retary shall implement the approaches identified in the re-  
18          port submitted under subsection (b)(1) for the ongoing,  
19          accurate, and timely collection and evaluation of data on  
20          health care disparities on the basis of race, ethnicity, gen-  
21          der, geography, or socioeconomic status.

1 **TITLE VI—HEALTH BUDGET;**  
2 **PAYMENTS; COST CONTAIN-**  
3 **MENT MEASURES**

4 **Subtitle A—Budgeting**

5 **SEC. 601. NATIONAL HEALTH BUDGET.**

6 (a) NATIONAL HEALTH BUDGET.—

7 (1) IN GENERAL.—By not later than September  
8 1 of each year, beginning with the year prior to the  
9 date on which benefits first become available as de-  
10 scribed in section 106(a), the Secretary shall estab-  
11 lish a national health budget, which specifies a budg-  
12 et for the total expenditures to be made for covered  
13 health care items and services under this Act.

14 (2) DIVISION OF BUDGET INTO COMPONENTS.—

15 The national health budget shall consist of the fol-  
16 lowing components:

17 (A) An operating budget.

18 (B) A capital expenditures budget.

19 (C) A special projects budget for purposes  
20 of allocating funds for capital expenditures and  
21 staffing needs of providers located in rural or  
22 medically underserved areas (as defined in sec-  
23 tion 330(b)(3) of the Public Health Service Act  
24 (42 U.S.C. 254b(b)(3))), including areas des-  
25 ignated as health professional shortage areas

1 (as defined in section 332(a) of the Public  
2 Health Service Act (42 U.S.C. 254e(a))).

3 (D) Quality assessment activities under  
4 title V.

5 (E) Health professional education expendi-  
6 tures.

7 (F) Administrative costs, including costs  
8 related to the operation of regional offices.

9 (G) A reserve fund to respond to the costs  
10 of treating an epidemic, pandemic, natural dis-  
11 aster, or other such health emergency, or mar-  
12 ket-shift adjustments related to patient volume.

13 (H) Prevention and public health activities.

14 (3) ALLOCATION AMONG COMPONENTS.—The  
15 Secretary shall allocate the funds received for pur-  
16 poses of carrying out this Act among the compo-  
17 nents described in paragraph (2) in a manner that  
18 ensures—

19 (A) that the operating budget allows for  
20 every participating provider in the Medicare for  
21 All Program to meet the needs of their respec-  
22 tive patient populations;

23 (B) that the special projects budget is suf-  
24 ficient to meet the health care needs within  
25 areas described in paragraph (2)(C) through

1 the construction, renovation, and staffing of  
2 health care facilities in a reasonable timeframe;

3 (C) a fair allocation for quality assessment  
4 activities; and

5 (D) that the health professional education  
6 expenditure component is sufficient to provide  
7 for the amount of health professional education  
8 expenditures sufficient to meet the need for cov-  
9 ered health care services.

10 (4) REGIONAL ALLOCATION.—The Secretary  
11 shall annually provide each regional office with an  
12 allotment the Secretary determines appropriate for  
13 purposes of carrying out this Act in such region, in-  
14 cluding payments to providers in such region, capital  
15 expenditures in such region, special projects in such  
16 region, health professional education in such region,  
17 administrative expenses in such region, and preven-  
18 tion and public health activities in such region.

19 (5) OPERATING BUDGET.—The operating budg-  
20 et described in paragraph (2)(A) shall be used for—

21 (A) payments to institutional providers  
22 pursuant to section 611; and

23 (B) payments to individual providers pur-  
24 suant to section 612.

1           (6) CAPITAL EXPENDITURES BUDGET.—The  
2 capital expenditures budget described in paragraph  
3 (2)(B) shall be used for—

4           (A) the construction or renovation of  
5 health care facilities, excluding congregate or  
6 segregated facilities for individuals with disabili-  
7 ties who receive long-term care services and  
8 support; and

9           (B) major equipment purchases.

10          (7) SPECIAL PROJECTS BUDGET.—The special  
11 projects budget shall be used for the construction of  
12 new facilities, major equipment purchases, and staff-  
13 ing in rural or medically underserved areas (as de-  
14 fined in section 330(b)(3) of the Public Health Serv-  
15 ice Act (42 U.S.C. 254b(b)(3))), including areas des-  
16 ignated as health professional shortage areas (as de-  
17 fined in section 332(a) of the Public Health Service  
18 Act (42 U.S.C. 254e(a))).

19          (8) TEMPORARY WORKER ASSISTANCE.—

20           (A) IN GENERAL.—For up to 5 years fol-  
21 lowing the date on which benefits first become  
22 available as described in section 106(a), at least  
23 1 percent of the budget shall be allocated to  
24 programs providing assistance to workers who  
25 perform functions in the administration of the

1 health insurance system, or related functions  
2 within health care institutions or organizations  
3 who may be affected by the implementation of  
4 this Act and who may experience economic dis-  
5 location as a result of the implementation of  
6 this Act.

7 (B) CLARIFICATION.—Assistance described  
8 in subparagraph (A) shall include wage replace-  
9 ment, retirement benefits, job training, and  
10 education benefits.

11 (b) DEFINITIONS.—In this section:

12 (1) CAPITAL EXPENDITURES.—The term “cap-  
13 ital expenditures” means expenses for the purchase,  
14 lease, construction, or renovation of capital facilities  
15 and for major equipment.

16 (2) HEALTH PROFESSIONAL EDUCATION EX-  
17 PENDITURES.—The term “health professional edu-  
18 cation expenditures” means expenditures in hospitals  
19 and other health care facilities to cover costs associ-  
20 ated with teaching and related research activities, in-  
21 cluding the impact of workforce diversity on patient  
22 outcomes.

## 1 **Subtitle B—Payments to Providers**

### 2 **SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS** 3 **BASED ON GLOBAL BUDGETS.**

4 (a) IN GENERAL.—Not later than the beginning of  
5 each fiscal quarter during which an institutional provider  
6 of care (including hospitals, skilled nursing facilities, Fed-  
7 erally qualified health centers, home health agencies, and  
8 independent dialysis facilities) is to furnish items and  
9 services under this Act, the Secretary shall pay to such  
10 institutional provider a lump sum in accordance with the  
11 succeeding provisions of this subsection and consistent  
12 with the following:

13 (1) PAYMENT IN FULL.—Such payment shall be  
14 considered as payment in full for all operating ex-  
15 penses for items and services furnished under this  
16 Act, whether inpatient or outpatient, by such pro-  
17 vider for such quarter, including outpatient or any  
18 other care provided by the institutional provider or  
19 provided by any health care provider who provided  
20 items and services pursuant to an agreement paid  
21 through the global budget as described in paragraph  
22 (3).

23 (2) QUARTERLY REVIEW.—The regional direc-  
24 tor, on a quarterly basis, shall review whether re-  
25 quirements of the institutional provider's participa-

1       tion agreement and negotiated global budget have  
2       been performed and shall determine whether adjust-  
3       ments to such institutional provider's payment are  
4       warranted. This review shall include consideration  
5       for additional funding necessary for unanticipated  
6       items and services for individuals with complex med-  
7       ical needs or market-shift adjustments related to pa-  
8       tient value. The review shall also include an assess-  
9       ment of any adjustments made to ensure that accu-  
10      racy and need for adjustment was appropriate.

11           (3) AGREEMENTS FOR SALARIED PAYMENTS  
12      FOR CERTAIN PROVIDERS.—Certain group practices  
13      and other health care providers, as determined by  
14      the Secretary, with agreements to provide items and  
15      services at a specified institutional provider paid a  
16      global budget under this subsection may elect to be  
17      paid through such institutional provider's global  
18      budget in lieu of payment under section 612 of this  
19      title. Any—

20           (A) individual health care professional of  
21           such group practice or other provider receiving  
22           payment through an institutional provider's  
23           global budget shall be paid on a salaried basis  
24           that is equivalent to salaries or other compensa-



1           tion rates negotiated for individual health care  
2           professionals of such institutional provider; and

3                   (B) any group practice or other health care  
4           provider that receives payment through an in-  
5           stitutional provider global budget under this  
6           paragraph shall be subject to the same report-  
7           ing and disclosure requirements of the institu-  
8           tional provider.

9           (b) PAYMENT AMOUNT.—

10                   (1) IN GENERAL.—The amount of each pay-  
11           ment to a provider described in subsection (a) shall  
12           be determined before the start of each fiscal year  
13           through negotiations between the provider and the  
14           regional director with jurisdiction over such pro-  
15           vider. Such amount shall be based on factors speci-  
16           fied in paragraph (2).

17                   (2) PAYMENT FACTORS.—Payments negotiated  
18           pursuant to paragraph (1) shall take into account,  
19           with respect to a provider—

20                           (A) the historical volume of services pro-  
21           vided for each item and services in the previous  
22           3-year period;

23                           (B) the actual expenditures of such pro-  
24           vider in such provider's most recent cost report

1 under title XVIII of the Social Security Act for  
2 each item and service compared to—

3 (i) such expenditures for other institu-  
4 tional providers in the director's jurisdic-  
5 tion; and

6 (ii) normative payment rates estab-  
7 lished under comparative payment rate  
8 systems, including any adjustments, for  
9 such items and services;

10 (C) projected changes in the volume and  
11 type of items and services to be furnished;

12 (D) wages for employees, including any  
13 necessary increases mandatory minimum safe  
14 registered nurse-to-patient ratios and optimal  
15 staffing levels for physicians and other health  
16 care workers;

17 (E) the provider's maximum capacity to  
18 provide items and services;

19 (F) education and prevention programs;

20 (G) permissible adjustment to the pro-  
21 vider's operating budget due to factors such  
22 as—

23 (i) an increase in primary or specialty  
24 care access;

1 (ii) efforts to decrease health care dis-  
2 parities in rural or medically underserved  
3 areas;

4 (iii) a response to emergent epidemic  
5 conditions; and

6 (iv) proposed new and innovative pa-  
7 tient care programs at the institutional  
8 level; and

9 (H) any other factor determined appro-  
10 priate by the Secretary.

11 (3) LIMITATION.—Payment amounts negotiated  
12 pursuant to paragraph (1) may not—

13 (A) take into account capital expenditures  
14 of the provider or any other expenditure not di-  
15 rectly associated with the provision of items and  
16 services by the provider to an individual;

17 (B) be used by a provider for capital ex-  
18 penditures or such other expenditures;

19 (C) exceed the provider's capacity to pro-  
20 vide care under this Act; or

21 (D) be used to pay or otherwise com-  
22 pensate any board member, executive, or ad-  
23 ministrator of the institutional provider who  
24 has any interest or relationship prohibited

1 under section 301(b)(2) of this Act or disclosed  
2 under section 301 of this Act.

3 (4) OPERATING EXPENSES.—For purposes of  
4 this subsection, “operating expenses” of a provider  
5 include the following:

6 (A) The cost of all items and services asso-  
7 ciated with the provision of inpatient care and  
8 outpatient care, including the following:

9 (i) Wages and salary costs for physi-  
10 cians, nurses, and other health care practi-  
11 tioners employed by an institutional pro-  
12 vider, including mandatory minimum safe  
13 registered nurse-to-patient staffing ratios  
14 and optimal staffing levels for physicians  
15 and other healthcare workers.

16 (ii) Wages and salary costs for all an-  
17 cillary staff and services.

18 (iii) Costs of all pharmaceutical prod-  
19 ucts administered by health care clinicians  
20 at the institutional provider’s facilities or  
21 through services provided in accordance  
22 with State licensing laws or regulations  
23 under which the institutional provider op-  
24 erates.

1 (iv) Purchasing and maintenance of  
2 medical devices, supplies, and other health  
3 care technologies, including diagnostic test-  
4 ing equipment.

5 (v) Costs of all incidental services nec-  
6 essary for safe patient care and handling.

7 (vi) Costs of patient care, education,  
8 and prevention programs, including occu-  
9 pational health and safety programs, public  
10 health programs, and necessary staff to  
11 implement such programs, for the contin-  
12 ued education and health and safety of cli-  
13 nicians and other individuals employed by  
14 the institutional provider.

15 (B) Administrative costs for the institu-  
16 tional provider.

17 (5) LIMITATION ON COMPENSATION.—Com-  
18 pensation costs for any employee or any contractor  
19 or any subcontractor employee of an institutional  
20 provider receiving global budgets under this section  
21 shall meet the compensation cap established in sec-  
22 tion 702 of the Bipartisan Budget Act of 2013 (41  
23 U.S.C. 4304(a)(16)) and implementing regulations.

24 (6) REGIONAL NEGOTIATIONS PERMITTED.—  
25 Subject to section 614, a regional director may nego-

1       tiate changes to an institutional provider’s global  
2       budget, including any adjustments to address un-  
3       foreseen market-shifts related to patient volume.

4       (c) BASELINE RATES AND ADJUSTMENTS.—

5           (1) IN GENERAL.—The Secretary shall use ex-  
6       isting prospective payment systems under title  
7       XVIII of the Social Security Act to serve as the  
8       comparative payment rate system in global budget  
9       negotiations described in subsection (b). The Sec-  
10      retary shall update such comparative payment rate  
11      systems annually.

12          (2) SPECIFICATIONS.—In developing the com-  
13      parative payment rate system, the Secretary shall  
14      use only the operating base payment rates under  
15      each such prospective payment systems with applica-  
16      ble adjustments.

17          (3) LIMITATION.—The comparative rate system  
18      established under this subsection shall not include  
19      the value-based payment adjustments and the cap-  
20      ital expenses base payment rates that may be in-  
21      cluded in such a prospective payment system.

22          (4) INITIAL YEAR.—In the first year that global  
23      budget payments under this Act are available to in-  
24      stitutional providers and for purposes of selecting a  
25      comparative payment rate system used during initial

1 global budget negotiations for each institutional pro-  
2 vider, the Secretary shall take into account the ap-  
3 propriate prospective payment system from the most  
4 recent year under title XVIII of the Social Security  
5 Act to determine what operating base payment the  
6 institutional provider would have been paid for cov-  
7 ered items and services furnished the preceding year  
8 with applicable adjustments, excluding value-based  
9 payment adjustments, based on such prospective  
10 payment system.

11 **SEC. 612. PAYMENT TO INDIVIDUAL PROVIDERS THROUGH**  
12 **FEE-FOR-SERVICE.**

13 (a) IN GENERAL.—In the case of a provider not de-  
14 scribed in section 611(a) (including those in group prac-  
15 tices who are not receiving payment on a salaried basis  
16 described in section 611(a)(3)), payment for items and  
17 services furnished under this Act for which payment is not  
18 otherwise made under section 611 shall be made by the  
19 Secretary in amounts determined under the fee schedule  
20 established pursuant to subsection (b). Such payment  
21 shall be considered to be payment in full for such items  
22 and services, and a provider receiving such payment may  
23 not charge the individual receiving such item or service  
24 in any amount.

25 (b) FEE SCHEDULE.—

1           (1) ESTABLISHMENT.—Not later than 1 year  
2 after the date of the enactment of this Act, and in  
3 consultation with providers and regional office direc-  
4 tors, the Secretary shall establish a national fee  
5 schedule for items and services payable under this  
6 Act. The Secretary shall evaluate the effectiveness of  
7 the fee-for-service structure and update such fee  
8 schedule annually.

9           (2) AMOUNTS.—In establishing payment  
10 amounts for items and services under the fee sched-  
11 ule established under paragraph (1), the Secretary  
12 shall take into account—

13                   (A) the amounts payable for such items  
14 and services under title XVIII of the Social Se-  
15 curity Act; and

16                   (B) the expertise of providers and value of  
17 items and services furnished by such providers.

18           (c) ELECTRONIC BILLING.—The Secretary shall es-  
19 tablish a uniform national system for electronic billing for  
20 purposes of making payments under this subsection.

21           (d) PHYSICIAN PRACTICE REVIEW BOARD.—Each di-  
22 rector of a regional office, in consultation with representa-  
23 tives of physicians practicing in that region, shall establish  
24 and appoint a physician practice review board to assure  
25 quality, cost effectiveness, and fair reimbursements for



1 physician-delivered items and services. The use of Quality-  
2 Adjusted Life Years, Disability-Adjusted Life Years, or  
3 other similar mechanisms that discriminate against people  
4 with disabilities is prohibited for use in any value or cost-  
5 effectiveness assessments.

6 **SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES**  
7 **UNDER THE MEDICARE PHYSICIAN FEE**  
8 **SCHEDULE.**

9 (a) STANDARDIZED AND DOCUMENTED REVIEW  
10 PROCESS.—Section 1848(c)(2) of the Social Security Act  
11 (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the  
12 end the following new subparagraph:

13 “(P) STANDARDIZED AND DOCUMENTED  
14 REVIEW PROCESS.—

15 “(i) IN GENERAL.—Not later than one  
16 year after the date of enactment of this  
17 subparagraph, the Secretary shall estab-  
18 lish, document, and make publicly avail-  
19 able, in consultation with the Office of Pri-  
20 mary Health Care, a standardized process  
21 for reviewing the relative values of physi-  
22 cians’ services under this paragraph.

23 “(ii) MINIMUM REQUIREMENTS.—The  
24 standardized process shall include, at a  
25 minimum, methods and criteria for identi-

1           fying services for review, prioritizing the  
2           review of services, reviewing stakeholder  
3           recommendations, and identifying addi-  
4           tional resources to be considered during  
5           the review process.”.

6           (b) PLANNED AND DOCUMENTED USE OF FUNDS.—  
7           Section 1848(c)(2)(M) of the Social Security Act (42  
8           U.S.C. 1395w-4(c)(2)(M)) is amended by adding at the  
9           end the following new clause:

10                   “(x) PLANNED AND DOCUMENTED  
11                   USE OF FUNDS.—For each fiscal year (be-  
12                   ginning with the first fiscal year beginning  
13                   on or after the date of enactment of this  
14                   clause), the Secretary shall provide to Con-  
15                   gress a written plan for using the funds  
16                   provided under clause (ix) to collect and  
17                   use information on physicians’ services in  
18                   the determination of relative values under  
19                   this subparagraph.”.

20           (c) INTERNAL TRACKING OF REVIEWS.—

21                   (1) IN GENERAL.—Not later than 1 year after  
22                   the date of enactment of this Act, the Secretary  
23                   shall submit to Congress a proposed plan for system-  
24                   atically and internally tracking the Secretary’s re-  
25                   view of the relative values of physicians’ services,

1 such as by establishing an internal database, under  
2 section 1848(c)(2) of the Social Security Act (42  
3 U.S.C. 1395w-4(c)(2)), as amended by this section.

4 (2) MINIMUM REQUIREMENTS.—The proposal  
5 shall include, at a minimum, plans and a timeline  
6 for achieving the ability to systematically and inter-  
7 nally track the following:

8 (A) When, how, and by whom services are  
9 identified for review.

10 (B) When services are reviewed or re-  
11 viewed or when new services are added.

12 (C) The resources, evidence, data, and rec-  
13 ommendations used in reviews.

14 (D) When relative values are adjusted.

15 (E) The rationale for final relative value  
16 decisions.

17 (d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of  
18 the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is  
19 amended—

20 (1) in subparagraph (B)(i), by striking “5” and  
21 inserting “4”; and

22 (2) in subparagraph (K)(i)(I), by striking “peri-  
23 odically” and inserting “annually”.

24 (e) CONSULTATION WITH MEDICARE PAYMENT AD-  
25 VISORY COMMISSION.—

1           (1) IN GENERAL.—Section 1848(c)(2) of the  
2 Social Security Act (42 U.S.C. 1395w-4(c)(2)) is  
3 amended—

4           (A) in subparagraph (B)(i), by inserting  
5 “in consultation with the Medicare Payment  
6 Advisory Commission,” after “The Secretary,”;  
7 and

8           (B) in subparagraph (K)(i)(I), as amended  
9 by subsection (d)(2), by inserting “, in coordi-  
10 nation with the Medicare Payment Advisory  
11 Commission,” after “annually”.

12           (2) CONFORMING AMENDMENTS.—Section 1805  
13 of the Social Security Act (42 U.S.C. 1395b-6) is  
14 amended—

15           (A) in subsection (b)(1)(A), by inserting  
16 the following before the semicolon at the end:  
17 “and including coordinating with the Secretary  
18 in accordance with section 1848(c)(2) to sys-  
19 tematically review the relative values established  
20 for physicians’ services, identify potentially  
21 misvalued services, and propose adjustments to  
22 the relative values for physicians’ services”; and

23           (B) in subsection (e)(1), in the second sen-  
24 tence, by inserting “or the Ranking Minority  
25 Member” after “the Chairman”.

1 (f) PERIODIC AUDIT BY THE COMPTROLLER GEN-  
 2 ERAL.—Section 1848(c)(2) of the Social Security Act (42  
 3 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is  
 4 amended by adding at the end the following new subpara-  
 5 graph:

6 “(Q) PERIODIC AUDIT BY THE COMP-  
 7 TROLLER GENERAL.—

8 “(i) IN GENERAL.—The Comptroller  
 9 General of the United States (in this sub-  
 10 section referred to as the ‘Comptroller  
 11 General’) shall periodically audit the review  
 12 by the Secretary of relative values estab-  
 13 lished under this paragraph for physicians’  
 14 services.

15 “(ii) ACCESS TO INFORMATION.—The  
 16 Comptroller General shall have unre-  
 17 stricted access to all deliberations, records,  
 18 and data related to the activities carried  
 19 out under this paragraph, in a timely man-  
 20 ner, upon request.”.

21 **SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**  
 22 **TURES; SPECIAL PROJECTS.**

23 (a) SENSE OF CONGRESS.—It is the sense of Con-  
 24 gress that tens of millions of people in the United States  
 25 do not receive healthcare services while billions of dollars

1 that could be spent on providing health care are diverted  
2 to profit. There is a moral imperative to correct the mas-  
3 sive deficiencies in our current health system and to elimi-  
4 nate profit from the provision of health care.

5 (b) PROHIBITIONS.—Payments to providers under  
6 this Act may not take into account, include any process  
7 for the provision of funding for, or be used by a provider  
8 for—

9 (1) marketing of the provider;

10 (2) the profit or net revenue of the provider, or  
11 increasing the profit or net revenue of the provider;

12 (3) incentive payments, bonuses, or other com-  
13 pensation based on patient utilization of items and  
14 services or any financial measure applied with re-  
15 spect to the provider (or any group practice, inte-  
16 grated health care delivery system, or other provider  
17 with which the provider contracts or has a pecuniary  
18 interest), including any value-based payment or em-  
19 ployment-based compensation;

20 (4) any agreement or arrangement described in  
21 section 203(a)(4) of the Labor-Management Report-  
22 ing and Disclosure Act of 1959 (29 U.S.C.  
23 433(a)(4)); or

1           (5) political or contributions prohibited under  
2 section 317 of the Federal Elections Campaign Act  
3 of 1971 (52 U.S.C. 30119(a)(1)).

4 (c) PAYMENTS FOR CAPITAL EXPENDITURES.—

5           (1) IN GENERAL.—The Secretary shall pay,  
6 from amounts made available for capital expendi-  
7 tures pursuant to section 601(a)(2)(B), such sums  
8 determined appropriate by the Secretary to providers  
9 who have submitted an application to the regional  
10 director of the region or regions in which the pro-  
11 vider operates or seeks to operate in a time and  
12 manner specified by the Secretary for purposes of  
13 funding capital expenditures of such providers.

14           (2) PRIORITY.—The Secretary shall prioritize  
15 allocation of funding under paragraph (1) to  
16 projects that propose to use such funds to improve  
17 service in a medically underserved area (as defined  
18 in section 330(b)(3) of the Public Health Service  
19 Act (42 U.S.C. 254b(b)(3))) or to address health  
20 disparities among racial, income, or ethnic groups,  
21 or based on geographic regions.

22           (3) LIMITATION.—The Secretary shall not  
23 grant funding for capital expenditures under this  
24 subsection for capital projects that are financed di-  
25 rectly or indirectly through the diversion of private

1 or other non-Medicare for All Program funding that  
2 results in reductions in care to patients, including  
3 reductions in registered nursing staffing patterns  
4 and changes in emergency room or primary care  
5 services or availability.

6 (4) CAPITAL PROJECTS FUNDED BY CHARITABLE DONATIONS.—Operating expenses and funds  
7 shall not be used by an institutional provider receiving  
8 payment for capital expenditures under this sub-  
9 section for a capital project funded by charitable do-  
10 nations without the approval of the regional director  
11 or directors of the region or regions where the cap-  
12 ital project is located.

13 (d) PROHIBITION AGAINST CO-MINGLING OPERATING AND CAPITAL FUNDS.—Providers that receive pay-  
14 ment under this title shall be prohibited from using, with  
15 respect to funds made available under this Act—

16 (1) funds designated for operating expenditures  
17 for capital expenditures or for profit; or

18 (2) funds designated for capital expenditures  
19 for operating expenditures.

20 (e) PAYMENTS FOR SPECIAL PROJECTS.—

21 (1) IN GENERAL.—The Secretary shall allocate  
22 to each regional director, from amounts made avail-  
23 able for special projects pursuant to section  
24  
25



1       601(a)(2)(C), such sums determined appropriate by  
2       the Secretary for purposes of funding projects de-  
3       scribed in such section, including the construction,  
4       renovation, or staffing of health care facilities, in  
5       rural, underserved, or health professional or medical  
6       shortage areas within such region. Each regional di-  
7       rector shall, prior to distributing such funds in ac-  
8       cordance with paragraph (2), present a budget de-  
9       scribing how such funds will be distributed to the  
10      Secretary.

11           (2) DISTRIBUTION.—A regional director shall  
12      distribute funds to providers operating in the region  
13      of such director’s jurisdiction in a manner deter-  
14      mined appropriate by the director.

15      (f) PROHIBITION ON FINANCIAL INCENTIVE  
16      METRICS IN PAYMENT DETERMINATIONS.—The Sec-  
17      retary may not utilize any quality metrics or standards  
18      for the purposes of establishing provider payment meth-  
19      odologies, programs, modifiers, or adjustments for pro-  
20      vider payments under this title.

21      **SEC. 615. OFFICE OF PRIMARY HEALTH CARE.**

22           (a) IN GENERAL.—There is established within the  
23      Agency for Healthcare Research and Quality an Office of  
24      Primary Health Care, responsible for coordinating with  
25      the Secretary, the Health Resources and Services Admin-

1 istration, and other offices in the Department as nec-  
2 essary, in order to—

3           (1) coordinate health professional education  
4 policies and goals, in consultation with the Secretary  
5 to achieve the national goals specified in subsection  
6 (b);

7           (2) develop and maintain a system to monitor  
8 the number and specialties of individuals through  
9 their health professional education, any postgraduate  
10 training, and professional practice;

11           (3) develop, coordinate, and promote policies  
12 that expand the number of primary care practi-  
13 tioners, registered nurses, midlevel practitioners, and  
14 dentists;

15           (4) recommend the appropriate training, tech-  
16 nical assistance, and patient protection enhance-  
17 ments of primary care health professionals, including  
18 registered nurses, to achieve uniform high quality  
19 and patient safety; and

20           (5) consult with the Secretary on the allocation  
21 of the special projects budget under section  
22 601(a)(2)(C).

23       (b) NATIONAL GOALS.—Not later than 1 year after  
24 the date of enactment of this Act, the Office of Primary  
25 Health Care shall set forth national goals to increase ac-

1 cess to high quality primary health care, particularly in  
2 underserved areas and for underserved populations.

3 (c) CLARIFICATION.—Nothing in this—

4 (1) section shall be construed to preempt any  
5 provision of State law establishing practice stand-  
6 ards or guidelines for health care professionals, in-  
7 cluding professional licensing or practice laws or reg-  
8 ulations; and

9 (2) Act shall be construed to require that any  
10 State impose additional educational standards or  
11 guidelines for health care professionals.

12 **SEC. 616. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**  
13 **PROVED DEVICES AND EQUIPMENT.**

14 The prices to be paid for covered pharmaceuticals,  
15 medical supplies, medical technologies, and medically nec-  
16 essary equipment covered under this Act shall be nego-  
17 tiated annually by the Secretary.

18 (1) IN GENERAL.—Notwithstanding any other  
19 provision of law, the Secretary shall, for fiscal years  
20 beginning on or after the date of the enactment of  
21 this subsection, negotiate with pharmaceutical man-  
22 ufacturers the prices (including discounts, rebates,  
23 and other price concessions) that may be charged to  
24 the Medicare for All Program during a negotiated  
25 price period (as specified by the Secretary) for cov-

1       ered drugs for eligible individuals under the Medi-  
2       care for All Program. In negotiating such prices  
3       under this section, the Secretary shall take into ac-  
4       count the following factors:

5               (A) The comparative clinical effectiveness  
6               and cost effectiveness, when available from an  
7               impartial source, of such drug.

8               (B) The budgetary impact of providing  
9               coverage of such drug.

10              (C) The number of similarly effective  
11              drugs or alternative treatment regimens for  
12              each approved use of such drug.

13              (D) The total revenues from global sales  
14              obtained by the manufacturer for such drug  
15              and the associated investment in research and  
16              development of such drug by the manufacturer.

17              (2) FINALIZATION OF NEGOTIATED PRICE.—

18       The negotiated price of each covered drug for a ne-  
19       gotiated price period shall be finalized not later than  
20       30 days before the first fiscal year in such nego-  
21       tiated price period.

22              (3) COMPETITIVE LICENSING AUTHORITY.—

23              (A) IN GENERAL.—Notwithstanding any  
24              exclusivity under clause (iii) or (iv) of section  
25              505(j)(5)(F) of the Federal Food, Drug, and

1           Cosmetic Act, clause (iii) or (iv) of section  
2           505(c)(3)(E) of such Act, section 351(k)(7)(A)  
3           of the Public Health Service Act, or section  
4           527(a) of the Federal Food, Drug, and Cos-  
5           metic Act, or by an extension of such exclusivity  
6           under section 505A of such Act or section 505E  
7           of such Act, and any other provision of law that  
8           provides for market exclusivity (or extension of  
9           market exclusivity) with respect to a drug, in  
10          the case that the Secretary is unable to success-  
11          fully negotiate an appropriate price for a cov-  
12          ered drug for a negotiated price period, the Sec-  
13          retary shall authorize the use of any patent,  
14          clinical trial data, or other exclusivity granted  
15          by the Federal Government with respect to such  
16          drug as the Secretary determines appropriate  
17          for purposes of manufacturing such drug for  
18          sale under Medicare for All Program. Any enti-  
19          ty making use of a competitive license to use  
20          patent, clinical trial data, or other exclusivity  
21          under this section shall provide to the manufac-  
22          turer holding such exclusivity reasonable com-  
23          pensation, as determined by the Secretary  
24          based on the following factors:

1 (i) The risk-adjusted value of any  
2 Federal Government subsidies and invest-  
3 ments in research and development used to  
4 support the development of such drug.

5 (ii) The risk-adjusted value of any in-  
6 vestment made by such manufacturer in  
7 the research and development of such  
8 drug.

9 (iii) The impact of the price, including  
10 license compensation payments, on meeting  
11 the medical need of all patients at a rea-  
12 sonable cost.

13 (iv) The relationship between the  
14 price of such drug, including compensation  
15 payments, and the health benefits of such  
16 drug.

17 (v) Other relevant factors determined  
18 appropriate by the Secretary to provide  
19 reasonable compensation.

20 (B) REASONABLE COMPENSATION.—The  
21 manufacturer described in subparagraph (A)  
22 may seek recovery against the United States in  
23 the United States Court of Federal Claims.

24 (C) INTERIM PERIOD.—Until 1 year after  
25 a drug described in subparagraph (A) is ap-

1           proved under section 505(j) of the Federal  
2           Food, Drug, and Cosmetic Act or section  
3           351(k) of the Public Health Service Act and is  
4           provided under license issued by the Secretary  
5           under such subparagraph, the Medicare for All  
6           Program shall not pay more for such drug than  
7           the average of the prices available, during the  
8           most recent 12-month period for which data is  
9           available prior to the beginning of such nego-  
10          tiated price period, from the manufacturer to  
11          any wholesaler, retailer, provider, health main-  
12          tenance organization, nonprofit entity, or gov-  
13          ernmental entity in the ten OECD (Organiza-  
14          tion for Economic Cooperation and Develop-  
15          ment) countries that have the largest gross do-  
16          mestic product with a per capita income that is  
17          not less than half the per capita income of the  
18          United States.

19                   (D) AUTHORIZATION FOR SECRETARY TO  
20                   PROCURE DRUGS DIRECTLY.—The Secretary  
21                   may procure a drug manufactured pursuant to  
22                   a competitive license under subparagraph (A)  
23                   for purposes of this Act.

24                   (4) FDA REVIEW OF LICENSED DRUG APPLICA-  
25                   TIONS.—The Secretary shall prioritize review of ap-

1        plications under section 505(j) of the Federal Food,  
2        Drug, and Cosmetic Act for drugs licensed under  
3        paragraph (3)(A).

4            (5) PROHIBITION OF ANTICOMPETITIVE BEHAV-  
5        IOR.—No drug manufacturer may engage in anti-  
6        competitive behavior with another manufacturer that  
7        may interfere with the issuance and implementation  
8        of a competitive license or run contrary to public  
9        policy.

10           (6) REQUIRED REPORTING.—The Secretary  
11        may require pharmaceutical manufacturers to dis-  
12        close to the Secretary such information that the Sec-  
13        retary determines necessary for purposes of carrying  
14        out this subsection.

## 15            **TITLE VII—UNIVERSAL** 16            **MEDICARE TRUST FUND**

### 17        **SEC. 701. UNIVERSAL MEDICARE TRUST FUND.**

18            (a) IN GENERAL.—There is hereby created on the  
19        books of the Treasury of the United States a trust fund  
20        to be known as the Universal Medicare Trust Fund (in  
21        this section referred to as the “Trust Fund”). The Trust  
22        Fund shall consist of such gifts and bequests as may be  
23        made and such amounts as may be deposited in, or appro-  
24        priated to, such Trust Fund as provided in this Act.

25            (b) APPROPRIATIONS INTO TRUST FUND.—



1           (1) TAXES.—There are appropriated to the  
2 Trust Fund for each fiscal year beginning with the  
3 fiscal year which includes the date on which benefits  
4 first become available as described in section 106,  
5 out of any moneys in the Treasury not otherwise ap-  
6 propriated, amounts equivalent to 100 percent of the  
7 net increase in revenues to the Treasury which is at-  
8 tributable to the amendments made by sections 801  
9 and 902. The amounts appropriated by the pre-  
10 ceding sentence shall be transferred from time to  
11 time (but not less frequently than monthly) from the  
12 general fund in the Treasury to the Trust Fund,  
13 such amounts to be determined on the basis of esti-  
14 mates by the Secretary of the Treasury of the taxes  
15 paid to or deposited into the Treasury, and proper  
16 adjustments shall be made in amounts subsequently  
17 transferred to the extent prior estimates were in ex-  
18 cess of or were less than the amounts that should  
19 have been so transferred.

20           (2) CURRENT PROGRAM RECEIPTS.—

21           (A) INITIAL YEAR.—Notwithstanding any  
22 other provision of law, there is appropriated to  
23 the Trust Fund for the fiscal year containing  
24 January 1 of the first year following the date  
25 of the enactment of this Act, an amount equal

1 to the aggregate amount appropriated for the  
2 preceding fiscal year for the following (in-  
3 creased by the consumer price index for all  
4 urban consumers for the fiscal year involved):

5 (i) The Medicare program under title  
6 XVIII of the Social Security Act (other  
7 than amounts attributable to any pre-  
8 miums under such title).

9 (ii) The Medicaid program under  
10 State plans approved under title XIX of  
11 such Act.

12 (iii) The Federal Employees Health  
13 Benefits program, under chapter 89 of title  
14 5, United States Code.

15 (iv) The TRICARE program, under  
16 chapter 55 of title 10, United States Code.

17 (v) The maternal and child health  
18 program (under title V of the Social Secu-  
19 rity Act), vocational rehabilitation pro-  
20 grams, programs for drug abuse and men-  
21 tal health services under the Public Health  
22 Service Act, programs providing general  
23 hospital or medical assistance, and any  
24 other Federal program identified by the  
25 Secretary, in consultation with the Sec-

1           retary of the Treasury, to the extent the  
2           programs provide for payment for health  
3           services the payment of which may be  
4           made under this Act.

5           (B) SUBSEQUENT YEARS.—Notwithstand-  
6           ing any other provision of law, there is appro-  
7           priated to the trust fund for the fiscal year con-  
8           taining January 1 of the second year following  
9           the date of the enactment of this Act, and for  
10          each fiscal year thereafter, an amount equal to  
11          the amount appropriated to the Trust Fund for  
12          the previous year, adjusted for reductions in  
13          costs resulting from the implementation of this  
14          Act, changes in the consumer price index for all  
15          urban consumers for the fiscal year involved,  
16          and other factors determined appropriate by the  
17          Secretary.

18          (3) RESTRICTIONS SHALL NOT APPLY.—Any  
19          other provision of law in effect on the date of enact-  
20          ment of this Act restricting the use of Federal funds  
21          for any reproductive health service shall not apply to  
22          monies in the Trust Fund.

23          (c) INCORPORATION OF PROVISIONS.—The provisions  
24          of subsections (b) through (i) of section 1817 of the Social  
25          Security Act (42 U.S.C. 1395i) shall apply to the Trust

1 Fund under this section in the same manner as such pro-  
 2 visions applied to the Federal Hospital Insurance Trust  
 3 Fund under such section 1817, except that, for purposes  
 4 of applying such subsections to this section, the “Board  
 5 of Trustees of the Trust Fund” shall mean the “Sec-  
 6 retary”.

7 (d) TRANSFER OF FUNDS.—Any amounts remaining  
 8 in the Federal Hospital Insurance Trust Fund under sec-  
 9 tion 1817 of the Social Security Act (42 U.S.C. 1395i)  
 10 or the Federal Supplementary Medical Insurance Trust  
 11 Fund under section 1841 of such Act (42 U.S.C. 1395t)  
 12 after the payment of claims for items and services fur-  
 13 nished under title XVIII of such Act have been completed,  
 14 shall be transferred into the Universal Medicare Trust  
 15 Fund under this section.

16 **TITLE VIII—CONFORMING**  
 17 **AMENDMENTS TO THE EM-**  
 18 **PLOYEE RETIREMENT IN-**  
 19 **COME SECURITY ACT OF 1974**

20 **SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**  
 21 **TIVE OF BENEFITS UNDER THE MEDICARE**  
 22 **FOR ALL PROGRAM; COORDINATION IN CASE**  
 23 **OF WORKERS’ COMPENSATION.**

24 (a) IN GENERAL.—Part 5 of subtitle B of title I of  
 25 the Employee Retirement Income Security Act of 1974

1 (29 U.S.C. 1131 et seq.) is amended by adding at the end  
2 the following new section:

3 **“SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**  
4 **CATIVE OF UNIVERSAL MEDICARE PROGRAM**  
5 **BENEFITS; COORDINATION IN CASE OF**  
6 **WORKERS’ COMPENSATION.**

7 “(a) IN GENERAL.—Subject to subsection (b), no em-  
8 ployee benefit plan may provide benefits that duplicate  
9 payment for any items or services for which payment may  
10 be made under the Medicare for All Act of 2019.

11 “(b) REIMBURSEMENT.—Each workers compensation  
12 carrier that is liable for payment for workers compensa-  
13 tion services furnished in a State shall reimburse the  
14 Medicare for All Program for the cost of such services.

15 “(c) DEFINITIONS.—In this subsection—

16 “(1) the term ‘workers compensation carrier’  
17 means an insurance company that underwrite work-  
18 ers compensation medical benefits with respect to  
19 one or more employers and includes an employer or  
20 fund that is financially at risk for the provision of  
21 workers compensation medical benefits;

22 “(2) the term ‘workers compensation medical  
23 benefits’ means, with respect to an enrollee who is  
24 an employee subject to the workers compensation  
25 laws of a State, the comprehensive medical benefits

1 for work-related injuries and illnesses provided for  
 2 under such laws with respect to such an employee;  
 3 and

4 “(3) the term ‘workers compensation services’  
 5 means items and services included in workers com-  
 6 pensation medical benefits and includes items and  
 7 services (including rehabilitation services and long-  
 8 term care services) commonly used for treatment of  
 9 work-related injuries and illnesses.”.

10 (b) CONFORMING AMENDMENT.—Section 4(b) of the  
 11 Employee Retirement Income Security Act of 1974 (29  
 12 U.S.C. 1003(b)) is amended by adding at the end the fol-  
 13 lowing: “Paragraph (3) shall apply subject to section  
 14 522(b) (relating to reimbursement of the Medicare for All  
 15 Program by workers compensation carriers).”.

16 (c) CLERICAL AMENDMENT.—The table of contents  
 17 in section 1 of such Act is amended by inserting after the  
 18 item relating to section 521 the following new item:

“Sec. 522. Prohibition of employee benefits duplicative of Universal Medicare  
 Program benefits; coordination in case of workers’ compensa-  
 tion.”.

19 **SEC. 802. APPLICATION OF CONTINUATION COVERAGE RE-**  
 20 **QUIREMENTS UNDER ERISA AND CERTAIN**  
 21 **OTHER REQUIREMENTS RELATING TO**  
 22 **GROUP HEALTH PLANS.**

23 (a) IN GENERAL.—Part 6 of subtitle B of title I of  
 24 the Employee Retirement Income Security Act of 1974

1 (29 U.S.C. 1161 et seq.) shall apply only with respect to  
 2 any employee health benefit plan that does not duplicate  
 3 payments for any items or services for which payment may  
 4 be made under the this Act.

5 (b) CONFORMING AMENDMENT.—Section 601 of part  
 6 6 of subtitle B of title I of the Employee Retirement In-  
 7 come Security Act of 1974 (19 U.S.C. 1161) is amended  
 8 by adding the following subsection at the end:

9 “(c) Subsection (a) shall apply to any group health  
 10 plan that does not duplicate payments for any items or  
 11 services for which payment may be made under the Uni-  
 12 versal Health Insurance Act of 2017.”.

13 **SEC. 803. EFFECTIVE DATE OF TITLE.**

14 The provisions of and amendments made by this title  
 15 shall take effect on the date described in section 106(a).

16 **TITLE IX—ADDITIONAL**  
 17 **CONFORMING AMENDMENTS**

18 **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**  
 19 **PROGRAMS.**

20 (a) MEDICARE, MEDICAID, AND STATE CHILDREN’S  
 21 HEALTH INSURANCE PROGRAM (SCHIP).—

22 (1) IN GENERAL.—Notwithstanding any other  
 23 provision of law and with respect to an individual el-  
 24 igible to enroll under this Act, subject to paragraphs  
 25 (2) and (3)—

1 (A) no benefits shall be available under  
2 title XVIII of the Social Security Act for any  
3 item or service furnished beginning on the date  
4 that is 2 years after the date of the enactment  
5 of this Act;

6 (B) no individual is entitled to medical as-  
7 sistance under a State plan approved under  
8 title XIX of such Act for any item or service  
9 furnished on or after such date;

10 (C) no individual is entitled to medical as-  
11 sistance under a State child health plan under  
12 title XXI of such Act for any item or service  
13 furnished on or after such date; and

14 (D) no payment shall be made to a State  
15 under section 1903(a) or 2105(a) of such Act  
16 with respect to medical assistance or child  
17 health assistance for any item or service fur-  
18 nished on or after such date.

19 (2) TRANSITION.—In the case of inpatient hos-  
20 pital services and extended care services during a  
21 continuous period of stay which began before the ef-  
22 fective date of benefits under section 106, and which  
23 had not ended as of such date, for which benefits  
24 are provided under title XVIII of the Social Security  
25 Act, under a State plan under title XIX of such Act,



1 or under a State child health plan under title XXI  
2 of such Act, the Secretary shall provide for continu-  
3 ation of benefits under such title or plan until the  
4 end of the period of stay.

5 (3) SCHOOL PROGRAMS.—All school related  
6 health programs, centers, initiatives, services, or  
7 other activities or work provided under title XIX or  
8 title XXI of the Social Security Act as of January  
9 1, 2019, shall be continued and covered by the Medi-  
10 care for All Program.

11 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-  
12 GRAM.—No benefits shall be made available under chapter  
13 89 of title 5, United States Code, with respect to items  
14 and services furnished to any individual eligible to enroll  
15 under this Act.

16 (c) TRICARE.—No benefits shall be made available  
17 under sections 1079 and 1086 of title 10, United States  
18 Code, for items or services furnished to any individual eli-  
19 gible to enroll under this Act.

20 (d) TREATMENT OF BENEFITS FOR VETERANS AND  
21 NATIVE AMERICANS.—

22 (1) IN GENERAL.—Nothing in this Act shall af-  
23 fect the eligibility of veterans for the medical bene-  
24 fits and services provided under title 38, United  
25 States Code, or of Indians for the medical benefits

1 and services provided by or through the Indian  
2 Health Service.

3 (2) REEVALUATION.—No reevaluation of the  
4 Indian Health Service shall be undertaken without  
5 consultation with tribal leaders and stakeholders.

6 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**  
7 **EXCHANGES.**

8 Effective on the date that is 2 years after the date  
9 of the enactment of this Act, the Federal and State Ex-  
10 changes established pursuant to title I of the Patient Pro-  
11 tection and Affordable Care Act (Public Law 111–148)  
12 shall terminate, and any other provision of law that relies  
13 upon participation in or enrollment through such an Ex-  
14 change, including such provisions of the Internal Revenue  
15 Code of 1986, shall cease to have force or effect.

16 **SEC. 903. SUNSET OF PROVISIONS RELATED TO PAY FOR**  
17 **PERFORMANCE PROGRAMS.**

18 (a) Effective on the date described in section 106(a),  
19 the Federal programs related to pay for performance pro-  
20 grams and value-based purchasing shall terminate, and  
21 any other provision of law that relies upon participation  
22 in or enrollment in such program shall cease to have force  
23 or effect. Programs that shall terminate include—

24 (1) the Merit-based Incentive Payment System  
25 established pursuant to subsection (q) of section

1 1848 of the Social Security Act (42 U.S.C. 1395w-  
2 4(q));

3 (2) the incentives for meaningful use of cer-  
4 tified EHR technology established pursuant to sub-  
5 section (a)(7) of section 1848 of the Social Security  
6 Act (42 U.S.C. 1395w-4(a)(7));

7 (3) the incentives for adoption and meaningful  
8 use of certified EHR technology established pursu-  
9 ant to subsection (o) of section 1848 of the Social  
10 Security Act (42 U.S.C. 1395w-4(o));

11 (4) alternative payment models established  
12 under section 1833(z) of the Social Security Act (42  
13 U.S.C. 1395(z)); and

14 (5) the following programs as established pur-  
15 suant to the following sections of the Patient Protec-  
16 tion and Affordable Care Act:

17 (A) Section 2701 (adult health quality  
18 measures).

19 (B) Section 2702 (payment adjustments  
20 for health care acquired conditions).

21 (C) Section 2706 (Pediatric Accountable  
22 Care Organization Demonstration Projects for  
23 the purposes of receiving incentive payments).

1 (D) Section 3002(b) (42 U.S.C. 1395w-  
2 4(a)(8)) (incentive payments for quality report-  
3 ing).

4 (E) Section 3001(a) (42 U.S.C.  
5 1395ww(o)) (Hospital Value-Based Purchas-  
6 ing).

7 (F) Section 3006 (value-based purchasing  
8 program for skilled nursing facilities and home  
9 health agencies).

10 (G) Section 3007 (42 U.S.C. 1395w-4(p))  
11 (value based payment modifier under physician  
12 fee schedule).

13 (H) Section 3008 (42 U.S.C. 1395ww(p))  
14 (payment adjustments for health care-acquired  
15 condition).

16 (I) Section 3022 (42 U.S.C. 1395jjj)  
17 (Medicare shared savings programs).

18 (J) Section 3023 (42 U.S.C. 1395cc-4)  
19 (National Pilot Program on Payment Bun-  
20 dling).

21 (K) Section 3024 (42 U.S.C. 1395cc-5)  
22 (Independence at home demonstration pro-  
23 gram).

24 (L) Section 3025 (42 U.S.C. 1395ww(q))  
25 (hospital readmissions reduction program).

1 (M) Section 10301 (plans for value-based  
2 purchasing program for ambulatory surgical  
3 centers).

4 **TITLE X—TRANSITION**  
5 **Subtitle A—Medicare for All Tran-**  
6 **sition Over 2 Years and Transi-**  
7 **tional Buy-In Option**

8 **SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO**  
9 **YEARS.**

10 Title XVIII of the Social Security Act (42 U.S.C.  
11 1395c et seq.) is amended by adding at the end the fol-  
12 lowing new section:

13 **“SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2**  
14 **YEARS.**

15 “(a) TRANSITION.—

16 “(1) IN GENERAL.—Every individual who meets  
17 the requirements described in paragraph (3) shall be  
18 eligible to enroll in the Medicare for All Program  
19 under this section during the transition period start-  
20 ing one year after the date of enactment of the  
21 Medicare for All Act of 2019.

22 “(2) BENEFITS.—An individual enrolled under  
23 this section is entitled to the benefits established  
24 under title II of the Medicare for All Act of 2019.

1           “(3) REQUIREMENTS FOR ELIGIBILITY.—The  
2 requirements described in this paragraph are the fol-  
3 lowing:

4           “(A) The individual meets the eligibility re-  
5 quirements established by the Secretary under  
6 title I of the Medicare for All Act of 2019.

7           “(B) The individual has attained the appli-  
8 cable year of age, or is currently enrolled in  
9 Medicare at the time of the transition to Medi-  
10 care for All.

11          “(4) APPLICABLE YEAR OF AGE DEFINED.—  
12 For purposes of this section, the term ‘applicable  
13 year of age’ means one year after the date of enact-  
14 ment of the Medicare for All Act of 2019, the age  
15 of 55 or older, the age 18 or younger.

16          “(b) ENROLLMENT; COVERAGE.—The Secretary shall  
17 establish enrollment periods and coverage under this sec-  
18 tion consistent with the principles for establishment of en-  
19 rollment periods and coverage for individuals under other  
20 provisions of this title. The Secretary shall establish such  
21 periods so that coverage under this section shall first begin  
22 on January 1 of the year on which an individual first be-  
23 comes eligible to enroll under this section.

24          “(c) SATISFACTION OF INDIVIDUAL MANDATE.—For  
25 purposes of applying section 5000A of the Internal Rev-

1 enue Code of 1986, the coverage provided under this sec-  
2 tion constitutes minimum essential coverage under sub-  
3 section (f)(1)(A)(i) of such section 5000A.

4 “(d) CONSULTATION.—In promulgating regulations  
5 to implement this section, the Secretary shall consult with  
6 interested parties, including groups representing bene-  
7 ficiaries, health care providers, employers, and insurance  
8 companies.”.

9 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**  
10 **TION BUY-IN.**

11 (a) IN GENERAL.—To carry out the purpose of this  
12 section, for the year beginning one year after the date of  
13 enactment of this Act and ending with the effective date  
14 described in section 106(a), the Secretary, acting through  
15 the Administrator of the Centers for Medicare & Medicaid  
16 (referred to in this section as the “Administrator”), shall  
17 establish, and provide for the offering through the Ex-  
18 changes, an option to buy in to the Medicare for All Pro-  
19 gram (in this Act referred to as the “Medicare Transition  
20 buy-in”).

21 (b) ADMINISTERING THE MEDICARE TRANSITION  
22 BUY-IN.—

23 (1) ADMINISTRATOR.—The Administrator shall  
24 administer the Medicare Transition buy-in in accord-  
25 ance with this section.

1           (2) APPLICATION OF ACA REQUIREMENTS.—  
2           Consistent with this section, the Medicare Transition  
3           buy-in shall comply with requirements under title I  
4           of the Patient Protection and Affordable Care Act  
5           (and the amendments made by that title) and title  
6           XXVII of the Public Health Service Act (42 U.S.C.  
7           300gg et seq.) that are applicable to qualified health  
8           plans offered through the Exchanges, subject to the  
9           limitation under subsection (e)(2).

10           (3) OFFERING THROUGH EXCHANGES.—The  
11           Medicare Transition buy-in shall be made available  
12           only through the Exchanges, and shall be available  
13           to individuals wishing to enroll and to qualified em-  
14           ployers (as defined in section 1312(f)(2) of the Pa-  
15           tient Protection and Affordable Care Act (42 U.S.C.  
16           18032)) who wish to make such plan available to  
17           their employees.

18           (4) ELIGIBILITY TO PURCHASE.—Any United  
19           States resident may enroll in the Medicare Transi-  
20           tion buy-in.

21           (c) BENEFITS; ACTUARIAL VALUE.—In carrying out  
22           this section, the Administrator shall ensure that the Medi-  
23           care Transition buy-in provides—

24           (1) coverage for the benefits required to be cov-  
25           ered under title II of this Act; and



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

4           (d) PROVIDERS AND REIMBURSEMENT RATES.—

5           (1) IN GENERAL.—With respect to the reim-  
6 bursement provided to health care providers for cov-  
7 ered benefits, as described in section 201, provided  
8 under the Medicare Transition buy-in, the Adminis-  
9 trator shall reimburse such providers at rates deter-  
10 mined for equivalent items and services under the  
11 Medicare for All fee-for-service schedule established  
12 in section 612(b) of this Act.

13           (2) PRESCRIPTION DRUGS.—Any payment rate  
14 under this subsection for a prescription drug shall be  
15 at the prices negotiated under section 616 of this  
16 Act.

17           (3) PARTICIPATING PROVIDERS.—

18           (A) IN GENERAL.—A health care provider  
19 that is a participating provider of services or  
20 supplier under the Medicare program under  
21 title XVIII of the Social Security Act (42  
22 U.S.C. 1395 et seq.) or under a State Medicaid  
23 plan under title XIX of such Act (42 U.S.C.  
24 1396 et seq.) on the date of enactment of this

1 Act shall be a participating provider in the  
2 Medicare Transition buy-in.

3 (B) ADDITIONAL PROVIDERS.—The Ad-  
4 ministrator shall establish a process to allow  
5 health care providers not described in subpara-  
6 graph (A) to become participating providers in  
7 the Medicare Transition buy-in. Such process  
8 shall be similar to the process applied to new  
9 providers under the Medicare program.

10 (e) PREMIUMS.—

11 (1) DETERMINATION.—The Administrator shall  
12 determine the premium amount for enrolling in the  
13 Medicare Transition buy-in, which—

14 (A) may vary according to family or indi-  
15 vidual coverage, age, and tobacco status (con-  
16 sistent with clauses (i), (iii), and (iv) of section  
17 2701(a)(1)(A) of the Public Health Service Act  
18 (42 U.S.C. 300gg(a)(1)(A))); and

19 (B) shall take into account the cost-shar-  
20 ing reductions and premium tax credits which  
21 will be available with respect to the plan under  
22 section 1402 of the Patient Protection and Af-  
23 fordable Care Act (42 U.S.C. 18071) and sec-  
24 tion 36B of the Internal Revenue Code of 1986,  
25 as amended by subsection (g).

1           (2) LIMITATION.—Variation in premium rates  
2           of the Medicare Transition buy-in by rating area, as  
3           described in clause (ii) of section 2701(a)(1)(A)(iii)  
4           of the Public Health Service Act (42 U.S.C.  
5           300gg(a)(1)(A)) is not permitted.

6           (f) TERMINATION.—This section shall cease to have  
7           force or effect on the effective date described in section  
8           106(a).

9           (g) TAX CREDITS AND COST-SHARING SUBSIDIES.—

10           (1) PREMIUM ASSISTANCE TAX CREDITS.—

11           (A) CREDITS ALLOWED TO MEDICARE  
12           TRANSITION BUY-IN ENROLLEES IN NON-EX-  
13           PANSION STATES.—Paragraph (1) of section  
14           36B(c) of the Internal Revenue Code of 1986  
15           is amended by redesignating subparagraphs (C)  
16           and (D) as subparagraphs (D) and (E), respec-  
17           tively, and by inserting after subparagraph (B)  
18           the following new subparagraph:

19           “(C) SPECIAL RULES FOR MEDICARE  
20           TRANSITION BUY-IN ENROLLEES.—

21           “(i) IN GENERAL.—In the case of a  
22           taxpayer who is covered, or whose spouse  
23           or dependent (as defined in section 152) is  
24           covered, by the Medicare Transition buy-in  
25           established under section 1002(a) of the

1 Medicare for All Act of 2019 for all  
2 months in the taxable year, subparagraph  
3 (A) shall be applied without regard to ‘but  
4 does not exceed 400 percent’.

5 “(ii) ENROLLEES IN MEDICAID NON-  
6 EXPANSION STATES.—In the case of a tax-  
7 payer residing in a State which (as of the  
8 date of the enactment of the Medicare for  
9 All Act of 2019) does not provide for eligi-  
10 bility under clause (i)(VIII) or (ii)(XX) of  
11 section 1902(a)(10)(A) of the Social Secu-  
12 rity Act for medical assistance under title  
13 XIX of such Act (or a waiver of the State  
14 plan approved under section 1115) who is  
15 covered, or whose spouse or dependent (as  
16 defined in section 152) is covered, by the  
17 Medicare Transition buy-in established  
18 under section 1002(a) of the Medicare for  
19 All Act of 2019 for all months in the tax-  
20 able year, subparagraphs (A) and (B) shall  
21 be applied by substituting ‘0 percent’ for  
22 ‘100 percent’ each place it appears.”.

23 (B) PREMIUM ASSISTANCE AMOUNTS FOR  
24 TAXPAYERS ENROLLED IN MEDICARE TRANSI-  
25 TION BUY-IN.—

1 (i) IN GENERAL.—Subparagraph (A)  
 2 of section 36B(b)(3) of such Code is  
 3 amended—(I) by redesignating clause (ii)  
 4 as clause (iii), (II) by striking “clause (ii)”  
 5 in clause (i) and inserting “clauses (ii) and  
 6 (iii)”, and (III) by inserting after clause (i)  
 7 the following new clause:  
 8 “(ii) SPECIAL RULES FOR TAXPAYERS  
 9 ENROLLED IN MEDICARE TRANSITION BUY-  
 10 IN.—In the case of a taxpayer who is cov-  
 11 ered, or whose spouse or dependent (as de-  
 12 fined in section 152) is covered, by the  
 13 Medicare Transition buy-in established  
 14 under section 1002(a) of the Medicare for  
 15 All Act of 2019 for all months in the tax-  
 16 able year, the applicable percentage for  
 17 any taxable year shall be determined in the  
 18 same manner as under clause (i), except  
 19 that the following table shall apply in lieu  
 20 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 .....	2.00	2.00
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	5.00.”.

1           (ii) CONFORMING AMENDMENT.—Sub-  
2           clause (I) of clause (iii) of section  
3           36B(b)(3) of such Code, as redesignated  
4           by subparagraph (A)(i), is amended by in-  
5           serting “, and determined after the appli-  
6           cation of clause (ii)” after “after applica-  
7           tion of this clause”.

8           (2) COST-SHARING SUBSIDIES.—Subsection (b)  
9           of section 1402 of the Patient Protection and Af-  
10          fordable Care Act (42 U.S.C. 18071(b)) is amend-  
11          ed—

12           (A) by inserting “, or in the Medicare  
13          Transition buy-in established under section  
14          1002(a) of the Medicare for All Act of 2019,”  
15          after “coverage” in paragraph (1);

16           (B) by redesignating paragraphs (1) (as so  
17          amended) and (2) as subparagraphs (A) and  
18          (B), respectively, and by moving such subpara-  
19          graphs 2 ems to the right;

20           (C) by striking “INSURED.—In this sec-  
21          tion” and inserting “INSURED.—

22          “(1) IN GENERAL.—In this section”;

23           (D) by striking the flush language; and

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

1 “(2) SPECIAL RULES.—

2 “(A) INDIVIDUALS LAWFULLY PRESENT.—

3 In the case of an individual described in section  
4 36B(c)(1)(B) of the Internal Revenue Code of  
5 1986, the individual shall be treated as having  
6 household income equal to 100 percent of the  
7 poverty line for a family of the size involved for  
8 purposes of applying this section.

9 “(B) MEDICARE TRANSITION BUY-IN EN-  
10 ROLLEES IN MEDICAID NON-EXPANSION  
11 STATES.—In the case of an individual residing  
12 in a State which (as of the date of the enact-  
13 ment of the Medicare for All Act of 2019) does  
14 not provide for eligibility under clause (i)(VIII)  
15 or (ii)(XX) of section 1902(a)(10)(A) of the So-  
16 cial Security Act for medical assistance under  
17 title XIX of such Act (or a waiver of the State  
18 plan approved under section 1115) who enrolls  
19 in such Medicare Transition buy-in, the pre-  
20 ceeding sentence, paragraph (1)(B), and para-  
21 graphs (1)(A)(i) and (2)(A) of subsection (c)  
22 shall each be applied by substituting ‘0 percent’  
23 for ‘100 percent’ each place it appears.”.

24 (h) CONFORMING AMENDMENTS.—

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

5 (A) in the paragraph heading, by inserting  
 6 “THE MEDICARE TRANSITION BUY-IN,” before  
 7 “AND”; and

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

10 (2) LEVEL PLAYING FIELD.—Section 1324(a)  
 11 of the Patient Protection and Affordable Care Act  
 12 (42 U.S.C. 18044(a)) is amended by inserting “the  
 13 Medicare Transition buy-in,” before “or a multi-  
 14 State qualified health plan”.

15 **Subtitle B—Transitional Medicare**  
 16 **Reforms**

17 **SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD**  
 18 **FOR MEDICARE COVERAGE FOR INDIVID-**  
 19 **UALS WITH DISABILITIES.**

20 (a) IN GENERAL.—Section 226(b) of the Social Secu-  
 21 rity Act (42 U.S.C. 426(b)) is amended—

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

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



1           (3) in paragraph (2)(C)(ii), by striking “, in-  
2           cluding the requirement that he has been entitled to  
3           the specified benefits for 24 months,”;

4           (4) in the first sentence, by striking “for each  
5           month beginning with the later of (I) July 1973 or  
6           (II) the twenty-fifth month of his entitlement or sta-  
7           tus as a qualified railroad retirement beneficiary de-  
8           scribed in paragraph (2), and” and inserting “for  
9           each month for which the individual meets the re-  
10          quirements of paragraph (2), beginning with the  
11          month following the month in which the individual  
12          meets the requirements of such paragraph, and”;  
13          and

14          (5) in the second sentence, by striking “the  
15          ‘twenty-fifth month of his entitlement’” and all that  
16          follows through “paragraph (2)(C) and”.

17          (b) CONFORMING AMENDMENTS.—

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

20                  (A) striking subsections (e)(1)(B), (f), and

21                  (h); and

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

24           (2) MEDICARE DESCRIPTION.—Section 1811(2)  
25          of the Social Security Act (42 U.S.C. 1395c(2)) is

1 amended by striking “have been entitled for not less  
2 than 24 months” and inserting “are entitled”.

3 (3) MEDICARE COVERAGE.—Section 1837(g)(1)  
4 of the Social Security Act (42 U.S.C. 1395p(g)(1))  
5 is amended by striking “25th month of” and insert-  
6 ing “month following the first month of”.

7 (4) RAILROAD RETIREMENT SYSTEM.—Section  
8 7(d)(2)(ii) of the Railroad Retirement Act of 1974  
9 (45 U.S.C. 231f(d)(2)(ii)) is amended—

10 (A) by striking “has been entitled to an  
11 annuity” and inserting “is entitled to an annu-  
12 ity”;

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

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

17 (e) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to insurance benefits under title  
19 XVIII of the Social Security Act with respect to items and  
20 services furnished in months beginning after December 1  
21 following the date of enactment of this Act, and before  
22 the date that is 2 years after the date of the enactment  
23 of such Act.

1 **SEC. 1012. ENSURING CONTINUITY OF CARE.**

2 (a) IN GENERAL.—The Secretary shall ensure that  
3 all persons enrolled or who seeks to enroll in a health plan  
4 during the transition period of the Medicare for All Pro-  
5 gram are protected from disruptions in their care during  
6 the transition period, including continuity of care with  
7 such persons current health care provider teams.

8 (b) CONTINUITY OF COVERAGE AND CARE IN GEN-  
9 ERAL.—During the transition period of the Medicare for  
10 All Act, group health plans and health insurance issuers  
11 offering group or individual health insurance coverage  
12 shall not end coverage for an enrollee during the transition  
13 period described in the Act until all ages are eligible to  
14 enroll in the Medicare for All Program except as expressly  
15 agreed upon under the terms of the plan.

16 (c) CONTINUITY OF COVERAGE AND CARE FOR PER-  
17 SONS WITH COMPLEX MEDICAL NEEDS.—

18 (1) The Secretary shall ensure that persons  
19 with disabilities, complex medical needs, or chronic  
20 conditions are protected from disruptions in their  
21 care during the transition period, including con-  
22 tinuity of care with such persons current health care  
23 provider teams.

24 (2) During the transition period of the Medi-  
25 care for All Act group health plans and health insur-

1       ance issuers offering group or individual health in-  
2       surance coverage shall not—

3               (A) end coverage for an enrollee who has  
4               a disability, complex medical need, or chronic  
5               condition during the transition period described  
6               in the Act until all ages are eligible to enroll in  
7               the Medicare for All Program; or

8               (B) impose any exclusion with respect to  
9               such plan or coverage on the basis of a person’s  
10              disability, complex medical need, or chronic con-  
11              dition during the transition period described  
12              under this Act until all ages are eligible to en-  
13              roll in the Medicare for All Program.

14       (d) PUBLIC CONSULTATION DURING TRANSITION.—  
15       The Secretary shall consult with communities and advo-  
16       cacy organizations of persons living with disabilities as  
17       well as other patient advocacy organizations to ensure that  
18       the transition buy-in takes into account the continuity of  
19       care for persons with disabilities, complex medical needs,  
20       or chronic conditions.

## 21       **TITLE XI—MISCELLANEOUS**

### 22       **SEC. 1101. DEFINITIONS.**

23       In this Act—

1           (1) the term “group practice” has the meaning  
2 given such term in section 1877(h)(4) of the Social  
3 Security Act (42 U.S.C. 1395nn(h)(4));

4           (2) the term “individual provider” means a sup-  
5 plier (as defined for purposes of paragraph (4));

6           (3) the term “institutional provider” means—

7               (A) providers of services described in sec-  
8 tion 1861(u) of such Act (42 U.S.C. 1395x(u));

9               (B) hospitals as defined in section 1861(e)  
10 of the Social Security Act (42 U.S.C.  
11 1395x(e)), and any outpatient settings or clinics  
12 operating within a hospital license or any set-  
13 ting or clinic that provides outpatient hospital  
14 services;

15               (C) psychiatric hospitals (as defined in sec-  
16 tion 1861(e) of the Social Security Act (42  
17 U.S.C. 1395x(f)));

18               (D) rehabilitation hospitals (as defined by  
19 the Secretary of Health and Human Services  
20 under section 1886(d)(1)(B)(ii) of the Social  
21 Security Act (42 U.S.C. 1395ww(d)(1)(B)(ii)));

22               (E) long-term care hospitals as defined in  
23 section 1861 of the Social Security Act (42  
24 U.S.C. 1395x(ccc)); and

1 (F) independent dialysis facilities and inde-  
2 pendent end-stage renal disease facilities as de-  
3 scribed in 42 CFR 413.174(b);

4 (4) the term “medically necessary or appro-  
5 priate” means the health care items and services or  
6 supplies are needed or appropriate to prevent, diag-  
7 nose, or treat an illness, injury, condition, disease, or  
8 its symptoms for an individual and are determined  
9 to be necessary or appropriate for such individual by  
10 the physician or other health care professional treat-  
11 ing such individual, after such professional performs  
12 an assessment of such individual’s condition, in a  
13 manner that meets—

14 (A) the scope of practice, licensing, and  
15 other law of the State in which such items and  
16 services are to be furnished; and

17 (B) appropriate standards established by  
18 the Secretary for purposes of carrying out this  
19 Act;

20 (5) the term “provider” means an institutional  
21 provider or a supplier (as defined in section 1861(d)  
22 of such Act (42 U.S.C. 1395x(d)) if the reference to  
23 “this title” were a reference to the Medicare for All  
24 Program);

1           (6) the term “Secretary” means the Secretary  
2 of Health and Human Services;

3           (7) the term “State” means a State, the Dis-  
4 trict of Columbia, or a territory of the United  
5 States; and

6           (8) the term “United States” shall include the  
7 States, the District of Columbia, and the territories  
8 of the United States.

9 **SEC. 1102. RULES OF CONSTRUCTION.**

10       (a) IN GENERAL.—A State or local government may  
11 set additional standards or apply other State or local laws  
12 with respect to eligibility, benefits, and minimum provider  
13 standards, only if such State or local standards—

14           (1) provide equal or greater eligibility than is  
15 available under this Act;

16           (2) provide equal or greater in-person access to  
17 benefits under this Act;

18           (3) do not reduce access to benefits under this  
19 Act;

20           (4) allow for the effective exercise of the profes-  
21 sional judgment of physicians or other health care  
22 professionals; and

23           (5) are otherwise consistent with this Act.

24       (b) RELATION TO STATE LICENSING LAW.—Nothing  
25 in this Act shall be construed to preempt State licensing,

1 practice, or educational laws or regulations with respect  
2 to health care professionals and health care providers, for  
3 such professionals and providers who practice in that  
4 State.

5 (c) APPLICATION TO STATE AND FEDERAL LAW ON  
6 WORKPLACE RIGHTS.—Nothing in this Act shall be con-  
7 strued to diminish or alter the rights, privileges, remedies,  
8 or obligations of any employee or employer under any Fed-  
9 eral or State law or regulation or under any collective bar-  
10 gaining agreement.

11 (d) RESTRICTIONS ON PROVIDERS.—With respect to  
12 any individuals or entities certified to provide items and  
13 services covered under section 201(a)(7), a State may not  
14 prohibit an individual or entity from participating in the  
15 program under this Act for reasons other than the ability  
16 of the individual or entity to provide such services.

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