H. R. 4683

To provide quality, affordable health care for all Americans.

IN THE HOUSE OF REPRESENTATIVES

February 1, 2006

Mr. Dingell (for himself, Mr. Stark, Mr. Brown of Ohio, Mr. Waxman, Mr. Rangel, Mr. Wynn, Mr. Strickland, Mr. Boucher, Ms. Baldwin, Ms. Schakowsky, Mr. Rush, Mr. Towns, Mr. Ross, Mr. Markey, Mr. Gene Green of Texas, and Mr. Allen) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce and Government Reform, 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 provide quality, affordable health care for all Americans.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Medicare for All Act”.

(b) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Medicare for all.
“TITLE XXII—MEDICARE FOR ALL

“Sec. 2201. Description of program.
“Sec. 2202. Eligibility, enrollment, and coverage.
“Sec. 2203. Benefits.
“Sec. 2204. Choice of coverage under private health care delivery systems.
“Sec. 2205. Medicare for All Trust Fund.
“Sec. 2206. Administration.

Sec. 3. Financing through employment tax.

SEC. 2. MEDICARE FOR ALL.

(a) ESTABLISHMENT OF PROGRAM.—The Social Security Act is amended by adding at the end the following:

“TITLE XXII—MEDICARE FOR ALL

“SEC. 2201. DESCRIPTION OF PROGRAM.

“The program under this title—

“(1) ensures that all Americans have high quality, affordable health care;

“(2) ensures that all Americans have access to health care as good as their Member of Congress receives; and

“(3) reduces the cost of health care and enhances American economic competitiveness in the global marketplace.

“SEC. 2202. ELIGIBILITY, ENROLLMENT, AND COVERAGE.

“(a) ELIGIBILITY.—

“(1) IN GENERAL.—Each eligible individual is entitled to benefits under the program under this title.

“(2) ELIGIBLE INDIVIDUAL.—
“(A) IN GENERAL.—For purposes of this title, the term ‘eligible individual’ means an individual who—

“(i) is—

“(I) a citizen of the United States; or

“(II) a person who is lawfully present in the United States; and

“(ii) is not eligible for benefits under part A or B of title XVIII.

“(B) LAWFULLY PRESENT.—For purposes of subparagraph (A)(i)(II), a person is lawfully present in the United States if such person—

“(i) is described in section 431 of Public Law 104–193;

“(ii) is described in section 103.12 of title 8, Code of Federal Regulations (as in effect as of the date of enactment of the Medicare for All Act);

“(iii) is eligible to apply for employment authorization from the Department of Homeland Security as listed in section 274a.12 of title 8, Code of Federal Regulations (as in effect as of the date of enactment of the Medicare for All Act); or
“(iv) is otherwise determined to be lawfully present in the United States under criteria established by the Secretary, in consultation with the Secretary of Homeland Security.

“(3) PHASE-IN OF ELIGIBILITY.—Under rules established by the Secretary, eligibility for benefits under this title shall be phased-in as follows:

“(A) During the first 5 years the program under this title is in operation, eligible individuals who are under 20 years of age or who are over 55 years of age are eligible for such benefits.

“(B) During the second 5 years the program under this title is in operation, eligible individuals who are under 30 years of age or who are over 45 years of age are eligible for such benefits.

“(C) All eligible individuals are eligible for such benefits beginning with the eleventh year in which the program under this title is in operation.

“(b) AUTOMATIC ENROLLMENT.—

“(1) IN GENERAL.—The Secretary shall establish a process under which each eligible individual is
deemed to be enrolled under the program under this
title. Such process shall include the following:

“(A) Deemed enrollment of an eligible in-
dividual upon birth in the United States.

“(B) Enrollment of eligible individuals at
the time of immigration into the United States.

“(2) ISSUANCE OF CARD.—The Secretary shall
provide for issuance of an appropriate card for indi-
viduals entitled to benefits under the program under
this title. Not later than the sixth year the program
under this title is in operation, the Secretary shall
ensure that each such card is linked securely, and
with strong privacy protections, to an electronic
health record for each such individual. In order to
accomplish such linkage, the Secretary is authorized
to award grants, issue contracts, alter reimburse-
ment under the program under this title, or provide
such other incentives as are reasonable and nec-
essary.

“(c) COVERAGE.—

“(1) IN GENERAL.—Subject to paragraph (2),
the Secretary shall provide for coverage of benefits
for items and services furnished on and after the
date an individual is entitled to benefits under the
program under this title.
'(2) INITIAL COVERAGE.—No coverage is available under the program under this title for items and services furnished before the date that is 18 months after the date of the enactment of the Medicare For All Act.

'(3) EXPIRATION OF COVERAGE.—An individual's coverage under the program under this title shall terminate as of the date the individual is no longer an eligible individual.

'(d) RELATION TO OTHER PROGRAMS.—

'(1) CONSTRUCTION.—

'(A) CONTINUED OPERATION OF PUBLIC PROGRAMS.—Nothing in this title shall be construed as requiring (or preventing) an individual who is entitled to benefits under the program under this title from obtaining benefits under any other public health care program to which the individual is entitled, including under a State Medicaid plan under title XIX, the State Children's Health Insurance Program under title XXI, a health program of the Department of Defense under chapter 55 of title 10, United States Code, a health program of the Department of Veterans Affairs under chapter 17 of title 38 of such Code, or a med-

•HR 4683 IH
ical care program of the Indian Health Service
or of a tribal organization. The provisions of
section 1928 shall apply to individuals insured
for vaccines for individuals under the age of 18.

“(B) CONTINUED OPERATION OF PRIVATE
HEALTH INSURANCE.—Nothing in this title
shall be construed as preventing an individual
who is entitled to benefits under the program
under this title from obtaining benefits that
supplement or improve the benefits available
under such program from any private health in-
surance plan or policy.

“(2) PRIMARY PAYOR; OTHER PUBLIC PRO-
GRAMS PROVIDING WRAP AROUND BENEFITS.—The
program under this title shall be primary payor to
other public health care benefit programs and the
benefits under such other public health care benefit
programs shall supplement the benefits under the
program under this title.

“SEC. 2203. BENEFITS.

“(a) COMPREHENSIVE BENEFIT PACKAGE.—The
Secretary shall provide for benefits under the program
under this title consistent with the following:

“(1) MEDICARE FEE-FOR-SERVICE BENEFITS.—
The benefits include the full range and scope of ben-
benefits available under the original fee-for-service pro-
gram under parts A and B of title XVIII.

“(2) Prescription drug coverage.—The
benefits include coverage of prescription drugs at
least as comprehensive as the prescription drug cov-
erage offered as of January 1, 2006, under the Blue
Cross/Blue Shield Standard Plan provided under the
Federal employees health benefits program under
chapter 89 of title 5, United States Code (in this
title referred to as ‘FEHBP’). Such coverage shall
be administered in the same manner as other bene-
fits under this section.

“(3) Inclusion of EPSDT.—The benefits in-
clude benefits for early and periodic screening, diag-
nostic, and treatment services (as defined in sections
1905(r), 1902(a)(43), and 1905(a)(4)(B)).

“(4) Parity in coverage of mental health
benefits.—

“(A) In general.—There shall not be any
treatment limitations or financial requirements
with respect to the coverage of benefits for
mental illnesses unless comparable treatment
limitations or financial requirements are im-
posed on medical and surgical benefits. Nothing
in this subparagraph shall be construed to re-
quire coverage for mental health benefits that are not medically necessary or to prohibit the appropriate medical management of such benefits.

“(B) RELATED DEFINITIONS.—For purposes of this paragraph—

“(i) FINANCIAL REQUIREMENTS.—The term ‘financial requirements’ includes deductibles, coinsurance, co-payments, other cost-sharing, and limitations on the total amount that may be paid by an individual with respect to benefits and shall include the application of annual and lifetime limits.

“(ii) MENTAL HEALTH BENEFITS.—The term ‘mental health benefits’ means benefits with respect to services for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV–TR), or the most recent edition if different than the Fourth Edition, if such services are included as part of an authorized treatment plan that is in accordance with standard protocols and such services
meet medical necessity criteria. Such term does not include benefits with respect to the treatment of substance abuse or chemical dependency.

“(iii) TREATMENT LIMITATIONS.—
The term ‘treatment limitations’ means limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment under the qualifying health benefit plan.

“(5) PREVENTIVE SERVICES.—The benefits shall include coverage of such additional preventive health care items and services as the Secretary shall specify, in consultation with the United States Preventive Services Task Force.

“(6) HOME AND COMMUNITY BASED SERVICES.—The benefits shall include coverage of home and community-based services described in section 1915(c)(4)(B).

“(7) ADDITIONAL BENEFITS.—The benefits shall include such additional benefits that the Secretary determines appropriate.

“(8) REVISION.—Nothing in this subsection shall be construed as preventing the Secretary from
improving the benefit package from time to time to account for changes in medical practice, new information from medical research, and other relevant developments in health science.

“(9) ADJUSTMENT AUTHORIZED.—The Secretary shall, on a regular basis, evaluate whether adding any of the benefits described in paragraphs (1) through (7) is necessary or advisable to promote the health of beneficiaries under the program under title XVIII. The Secretary is authorized to improve the benefits available under such program, based upon such evaluation.

“(b) COST-SHARING.—

“(1) IN GENERAL.—Except as otherwise provided under this subsection or subsection (a)(4), with respect to the benefits described in subsection (a)(1), such benefits shall be subject to the cost-sharing (in the form of deductibles, coinsurance, and copayments) and premiums applicable under the program described in such subsection.

“(2) PRESCRIPTION DRUG COVERAGE.—With respect to the benefits described in subsection (a)(2), such benefits shall be subject to the cost-sharing (in the form of deductibles, coinsurance, and copay-
ments) applicable under the plan described in such subsection.

“(3) Treatment of Preventive and Additional Services.—With respect to benefits described in paragraphs (5) and (7) of subsection (a), such benefits shall be subject to cost-sharing (in the form of deductibles, coinsurance, and copayments) that is consistent (as determined by the Secretary) with the cost-sharing applicable under paragraph (1).

“(4) Treatment of EPSDT and Home and Community-Based Services.—With respect to benefits described in paragraphs (3) and (6) of subsection (a), such benefits shall be subject to nominal cost-sharing (in the form of deductibles, coinsurance, and copayments) that is consistent (as determined by the Secretary) with the cost-sharing applicable to such services under section 1916 (as in effect on January 1, 2006).

“(5) Reduction in Cost-sharing for Low-income Individuals.—The Secretary shall provide for reduced cost-sharing for low-income individuals in a manner that is no less protective than the reduced cost-sharing for individuals under section 1902(a)(10)(E) (as in effect on January 1, 2006).
“(c) Freedom to Choose Your Own Doctor and Health Plan.—Except in the case of individuals who elect enrollment in a private health plan under section 2204, the provisions of section 1802 shall apply under this title.

“(d) Payment Schedule.—

“(1) In General.—The Secretary, with the assistance of the Medicare Payment Advisory Commission, shall develop and implement a payment schedule for benefits covered under the program under this title which are provided other than through private health plans. To the extent feasible, such payment schedule shall be consistent with comparable payment schedules and reimbursement methodologies applied to benefits provided under parts A and B of title XVIII, except, that with respect to the coverage of prescription drugs, the Secretary shall provide for payment in accordance with a payment schedule developed and implemented under the previous sentence.

“(2) Additional Payments for Quality.—The Secretary shall establish procedures to provide reimbursement in addition to the reimbursement under paragraph (1) to health care providers that achieve measures (as established by the Secretary in
consultation with health care professionals and
groups representing eligible individuals) of health
care quality. The Secretary shall ensure that such
measures include measures of appropriate use of
health information technology.

“(e) Application of Beneficiary Protec-
tions.—The Secretary shall provide for protections of
beneficiaries under the program under this title that are
not less than the beneficiary protections provided under
title XVIII, including appeal rights and limitations on bal-
ance billing.

“SEC. 2204. CHOICE OF COVERAGE UNDER PRIVATE
HEALTH CARE DELIVERY SYSTEMS.

“(a) In General.—The Secretary shall provide a
process for—

“(1) the offering of private health plans for the
provision of benefits under the program under this
title; and

“(2) the enrollment, disenrollment, termination,
and change in enrollment of eligible individuals in
such plans.

“(b) Offering of Private Health Plans.—

“(1) In General.—The Secretary shall enter
into contracts with qualified entities for the offering
of private health plans under the program under this
title. In entering into such contracts the Secretary shall have the same authority that the Director of the Office of Personnel Management has with respect to health benefits plans under FEHBP.

“(2) REQUIREMENTS.—The Secretary shall not enter into such a contract for the offering of a private health plan under the program under this title unless at least the following requirements are met:

“(A) BENEFITS AS GOOD AS YOUR CONGRESSMAN GETS.—Benefits under such plans are not less than the benefits offered to Members of Congress and Federal employees under FEHBP. Such plans may provide health benefits in addition to such required benefits and may impose a premium for the provision of benefits. Such plans may not provide for financial payments or rebates to enrollees.

“(B) BENEFICIARY PROTECTIONS.—Enrollees in such plans have beneficiary protections that are not less than the beneficiary protections applicable under this title to individuals not so enrolled and shall include beneficiary protections applicable under both FEHBP and part C of title XVIII.
“(C) Other Administrative Requirements.—The plans are subject to such requirements relating to licensure and solvency, protection against fraud and abuse, inspection, disclosure, periodic auditing, and administrative operations and efficiencies as the Secretary identifies, taking into account similar requirements under FEHBP and part C of title XVIII.

“(e) Annual Open Enrollment.—The process under subsection (a)(2) shall provide for an annual open enrollment period in which individuals may enroll, and change or terminate enrollment, in private health plans in a manner similar to that provided under FEHBP as of January 1, 2006.

“(d) Payment to Private Health Plans.—

“(1) In General.—In the case of an individual enrolled in a private health plan under this section for a month, the Secretary shall provide for payment of an amount equal to \( \frac{1}{12} \) of the annual per capita amount (described in paragraph (2), as adjusted under paragraph (3)).

“(2) Annual Per Capita Amount.—The annual per capita amount under this paragraph shall be the annual average per capita cost of providing benefits under the program under this title (includ-
ing both individuals enrolled and not enrolled under
private health plan), as computed by the Secretary
based on rules similar to the rules described in sec-
tion 1876(a)(4).

“(3) Risk-adjustment.—In making payment
under this subsection, the Secretary shall apply risk
adjustment factors similar to those applied to pay-
ments to Medicare Advantage organizations under
section 1853, except that the Secretary shall ensure
that payments under this subsection are adjusted
based on such factors to ensure that the health sta-
tus of the enrollee is reflected in such adjusted pay-
ments, including adjusting for the difference between
the health status of the enrollee and individuals re-
ceiving benefits under the program under this title
who are not so enrolled. Payments under this sub-
section must, in aggregate, reflect such differences.

“(e) Requirements for FEHBP Carriers.—
Each contract entered into or renewed under section 8902
of title 5, United States Code, shall require the carrier
to offer a plan under this section on similar terms and
conditions to the plan offered by the carrier under
FEHBP.
“SEC. 2205. MEDICARE FOR ALL TRUST FUND.

“(a) Establishment of Trust Fund.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ‘Medicare for All Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

“(b) Transfers to Trust Fund.—There are hereby appropriated to the Medicare for All Trust Fund, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to—

“(1) the taxes received in the Treasury under sections 1401(c), 3101(c), and 3111(c) of the Internal Revenue Code of 1986;

“(2) such portion of the taxes received in the Treasury under section 3201 as are attributable to the rate specified in section 3101(c) of such Code;

“(3) such portion of the taxes received in the Treasury under section 3211 of such Code as are attributable to the sum of the rates specified in section 3101(c) and 3111(c) of such Code; and

“(4) such portion of the taxes received in the Treasury under section 3221 as are attributable to the rate specified in section 3111(c) of such Code.
The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

“(c) INCORPORATION OF PROVISIONS.—

“(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1817 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Hospital Insurance Trust Fund and part A of title XVIII, respectively.

“(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1817 under paragraph (1)—

“(A) any reference in such section to ‘this part’ is construed to refer to this title;

“(B) any reference to taxes referred to in subsection (a) of such section shall be construed to refer to the taxes referred to in subsection (b) of this section; and
“(C) the Board of Trustees of the Medicare for All Trust Fund shall be the same as the Board of Trustees of the Federal Hospital Insurance Trust Fund.

“SEC. 2206. ADMINISTRATION.

“Except as otherwise provided in this title—

“(1) the Secretary shall enter into appropriate contracts with providers of services, other health care providers, and Medicare administrative contractors, taking into account the types of contracts used under title XVIII with respect to such entities, to administer the program under this title;

“(2) benefits described in section 2203 that are payable under the program under this title to such individuals shall be paid in a manner specified by the Secretary (taking into account, and based to the greatest extent practicable upon, the manner in which they are provided under title XVIII); and

“(3) provider participation agreements under title XVIII shall apply to enrollees and benefits under the program under this title in the same manner as they apply to enrollees and benefits under the program under title XVIII.”.

(b) CONFORMING AMENDMENTS TO SOCIAL SECURITY ACT PROVISIONS.—
(1) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended—

(A) by striking “or the Federal Supplementary” and inserting “the Federal Supplementary”; and

(B) by inserting “or the Medicare for All Trust Fund” after “such Trust Fund”).

(2) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking “and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII” and inserting “, the Federal Supplementary Medical Insurance Trust Fund established by title XVIII, and the Medicare for All Trust Fund established under title XXII”.

(c) MAINTENANCE OF MEDICAID ELIGIBILITY AND BENEFITS.—In order for a State to continue to be eligible for payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) the State may not reduce standards of eligibility or benefits provided under its State Medicaid plan under title XIX of the Social Security Act below such standards of eligibility and benefits in effect on the date of the enactment of this Act.

SEC. 3. FINANCING THROUGH EMPLOYMENT TAX.

(a) TAX ON EMPLOYEES.—Section 3101 of the Internal Revenue Code of 1986 is amended by redesignating
subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

“(c) MEDICARE FOR ALL.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to 1.7 percent of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b)).”.

(b) TAX ON EMPLOYERS.—Section 3111 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

“(c) MEDICARE FOR ALL.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 7 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).”.

(c) TAX ON SELF-EMPLOYMENT.—Section 1401 of such Code is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

“(c) MEDICARE FOR ALL.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the applicable percent of the self-employment income
for such taxable year. For purposes of the preceding sentence, the applicable percent is a percent equal to the sum of the percent described in section 3101(c) plus the percent described in section 3111(c).”.

(d) Railroad Retirement Tax.—

(1) Tax on employees.—Section 3201(a) of such Code is amended by striking “subsections (a) and (b) of section 3101” and inserting “subsections (a), (b), and (c) of section 3101”.

(2) Tax on employee representatives.—

Section 3211(a) of such Code is amended by striking “subsections (a) and (b) of section 3101 and subsections (a) and (b) of section 3111” and inserting “subsections (a), (b), and (c) of section 3101 and subsections (a), (b), and (c) of section 3111”.

(3) Tax on employers.—Section 3221(a) of such Code is amended by striking “subsections (a) and (b) of section 3111” and inserting “subsections (a), (b), and (c) of section 3111”.

(4) Determination of contribution base.—Clause (iii) of section 3231(e)(2)(A) is amended to read as follows:

“(iii) Hospital insurance and Medicare for all taxes.—Clause (i) shall not apply to—
“(I) so much of the rate applicable under section 3201(a) or 3221(a) as does not exceed the sum of the rates of tax in effect under subsections (b) and (c) of section 3101, and

“(II) so much of the rate applicable under section 3211(a) as does not exceed the sum of the rates of tax in effect under subsections (b) and (c) of section 1401.”.

(e) Application of Tax to Federal, State, and Local Employment.—Paragraphs (1) and (2) of section 3121(u) and section 3125(a) of such Code are each amended by striking “sections 3101(b) and 3111(b)” and inserting “subsections (b) and (c) of section 3101 and subsections (b) and (c) of section 3111”.

(f) Conforming Amendments.—

(1) Section 1402(a)(12)(B) of such Code is amended by striking “subsections (a) and (b) of section 1401” and inserting “subsections (a), (b), and (c) of section 1401”.

(2) Section 3121(q) of such Code is amended by striking “subsections (a) and (b) of section
3111” and inserting “subsections (a), (b), and (c) of section 3111”.

(3) The last sentence of section 6051(a) of such Code is amended by striking “sections 3101(c) and 3111(c)” and inserting “sections 3101(d) and 3111(d)”.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to wages paid and self-employment income derived on or after January 1 of the year following the date of the enactment of this Act.