I

116TH CONGRESS
1ST SESSION

H. R. 1384

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

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. GALLEGO, 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. VISCLOSKY, 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-

cess to health care. In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtaining health care items and services provided under the program established under this Act.

SEC. 103. FREEDOM OF CHOICE.

Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act.

SEC. 104. NON-DISCRIMINATION.

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in or be denied the benefits of the program established under this Act (except as expressly authorized by this Act for purposes of enforcing eligibility standards described in section 102), or be subject to any reduction of benefits or other discrimination by any participating provider (as defined in section 301), or any entity conducting, 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

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

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

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

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or

(2) an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act.

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

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

SEC. 201. COMPREHENSIVE BENEFITS.

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

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

(2) Ambulatory patient services.

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

(4) Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products.

(5) Mental health and substance abuse treatment services, including inpatient care.

(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 quirements 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—

(A) the contract and provider meet the requirements specified in paragraphs (3) and (4), respectively;

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

(C) the provider receives—

(i) no reimbursement under this Act directly or indirectly for such item or service, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such items or service under this Act directly or indirectly.

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

(A) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(B) not be entered into at a time when the individual is facing an emergency health care 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

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

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

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

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

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

(E) levels of funding;

(F) methods for determining amounts of payments to providers of covered items and 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 measures, and long-range plans and goals for achievements in such areas.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this Act.

(M) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Secretary may, either directly or by contract—

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

(B) develop and test methods of delivery of items and services as the Secretary may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act; and

(C) develop methodological standards for policymaking.

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of 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(c),
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.

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

(4) Development of minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality reviews in the administrative regions. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the region and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Center shall ensure coordination and reporting by such entities to ensure national consistency in quality standards.

(5) Submission of a report to the Secretary annually specifically on findings from outcomes research and development of practice guidelines that may affect the Secretary's determination of coverage of services under section 401(a)(1)(G).

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and 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.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services under this Act.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health budget shall consist of the following components:

(A) An operating budget.

(B) A capital expenditures budget.

(C) A special projects budget for purposes of allocating funds for capital expenditures and staffing needs of providers located in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated 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.

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

(A) the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term care services and support; and

(B) major equipment purchases.

(7) SPECIAL PROJECTS BUDGET.—The special projects budget shall be used for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))).

(8) TEMPORARY WORKER ASSISTANCE.—

(A) IN GENERAL.—For up to 5 years following the date on which benefits first become available as described in section 106(a), at least 1 percent of the budget shall be allocated to programs providing assistance to workers who 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

global budget negotiations for each institutional provider, the Secretary shall take into account the appropriate prospective payment system from the most recent year under title XVIII of the Social Security Act to determine what operating base payment the institutional provider would have been paid for covered items and services furnished the preceding year with applicable adjustments, excluding value-based payment adjustments, based on such prospective payment system.

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

(a) IN GENERAL.—In the case of a provider not described in section 611(a) (including those in group practices who are not receiving payment on a salaried basis described in section 611(a)(3)), payment for items and services furnished under this Act for which payment is not otherwise made under section 611 shall be made by the Secretary in amounts determined under the fee schedule established pursuant to subsection (b). Such payment shall be considered to be payment in full for such items and services, and a provider receiving such payment may not charge the individual receiving such item or service in any amount.

(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 CHARI-
7 TABLE DONATIONS.—Operating expenses and funds
8 shall not by used by an institutional provider receiv-
9 ing payment for capital expenditures under this sub-
10 section for a capital project funded by charitable do-
11 nations without the approval of the regional director
12 or directors of the region or regions where the cap-
13 ital project is located.

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

18 (1) funds designated for operating expenditures
19 for capital expenditures or for profit; or

20 (2) funds designated for capital expenditures
21 for operating expenditures.

22 (e) PAYMENTS FOR SPECIAL PROJECTS.—

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

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-

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

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

(6) REQUIRED REPORTING.—The Secretary may require pharmaceutical manufacturers to disclose to the Secretary such information that the Secretary determines necessary for purposes of carrying out this subsection.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Universal Medicare 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 and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(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' compensation.''.

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,

or under a State child health plan under title XXI of such Act, the Secretary shall provide for continuation of benefits under such title or plan until the end of the period of stay.

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

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

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

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

(1) IN GENERAL.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits

and services provided by or through the Indian Health Service.

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

SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE EXCHANGES.

Effective on the date that is 2 years after the date of the enactment of this Act, the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

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

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

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

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

(2) the incentives for meaningful use of certified EHR technology established pursuant to subsection (a)(7) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(a)(7));

(3) the incentives for adoption and meaningful use of certified EHR technology established pursuant to subsection (o) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(o));

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

(5) the following programs as established pursuant to the following sections of the Patient Protection and Affordable Care Act:

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

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

(C) Section 2706 (Pediatric Accountable Care Organization Demonstration Projects for 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).

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

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.

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

"SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2 YEARS.

"(a) TRANSITION.—

"(1) IN GENERAL.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll in the Medicare for All Program under this section during the transition period starting one year after the date of enactment of the Medicare for All Act of 2019.

"(2) BENEFITS.—An individual enrolled under this section is entitled to the benefits established 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 ceding 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 (c) 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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