I

118TH CONGRESS
1ST SESSION

H. R. 3421

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

IN THE HOUSE OF REPRESENTATIVES

MAY 17, 2023

Ms. JAYAPAL (for herself, Mrs. DINGELL, Ms. ADAMS, Ms. BALINT, Ms. BARRAGÁN, Mr. BEYER, Mr. BLUMENAUER, Ms. BONAMICI, Mr. BOWMAN, Mr. BOYLE of Pennsylvania, Ms. BROWN, Ms. BUSH, Mr. CARBAJAL, Mr. CÁRDENAS, Mr. CARSON, Mr. CARTER of Louisiana, Mr. CARTWRIGHT, Mr. CASAR, Mrs. CHERFILUS-MCCORMICK, Ms. CHU, Mr. CICILLINE, Ms. CLARKE of New York, Mr. CLEAVER, Mr. COHEN, Ms. CROCKETT, Mr. DAVIS of Illinois, Ms. DEGETTE, Mr. DELUZIO, Mr. DESAULNIER, Mr. DOGGETT, Ms. ESCOBAR, Mr. ESPAILLAT, Mrs. FOUSHEE, Ms. LOIS FRANKEL of Florida, Mr. FROST, Mr. GARAMENDI, Mr. ROBERT GARCIA of California, Mr. GARCÍA of Illinois, Mr. GOLDMAN of New York, Mr. GOMEZ, Mr. GREEN of Texas, Mr. GRIJALVA, Mr. HARDER of California, Mrs. HAYES, Mr. HIGGINS of New York, Ms. HOYLE of Oregon, Mr. HUFFMAN, Mr. IVEY, Mr. JACKSON of Illinois, Ms. JACKSON LEE, Ms. JACOBS, Mr. JOHNSON of Georgia, Ms. KAMLAGER-DOVE, Mr. KEATING, Ms. KELLY of Illinois, Mr. KHANNA, Ms. LEE of California, Ms. LEE of Pennsylvania, Ms. LEGER FERNANDEZ, Mr. LEVIN, Mr. LIEU, Ms. MCCOLLUM, Mr. MCGARVEY, Mr. MCGOVERN, Mr. MEEKS, Ms. MENG, Mr. MFUME, Mr. MULLIN, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Ms. NORTON, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PALLONE, Mr. PANETTA, Mr. PAYNE, Ms. PINGREE, Mr. POCAN, Ms. PORTER, Ms. PRESSLEY, Mr. QUIGLEY, Mrs. RAMIREZ, Mr. RASKIN, Mr. SABLAN, Ms. SALINAS, Ms. SÁNCHEZ, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SHERMAN, Mr. SMITH of Washington, Ms. STANSBURY, Mr. SWALWELL, Mr. TAKANO, Mr. THANEDAR, Mr. THOMPSON of California, Mr. THOMPSON of Mississippi, Ms. TITUS, Ms. TLAIB, Ms. TOKUDA, Mr. TONKO, Mr. TORRES of New York, Mrs. TRAHAN, Mr. VARGAS, Ms. VELÁZQUEZ, Ms. WATERS, Mrs. WATSON COLEMAN, Ms. WILD, Ms. WILLIAMS of Georgia, Ms. WILSON of Florida, and Ms. LOFGREN) 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 the Workforce, Rules, Oversight and Accountability, Armed Services, and the Judiciary, 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".
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; other limitations.
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 Health Equity.
Sec. 616. Office of Primary Care.
Sec. 617. 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.
Sec. 1103. No use of resources for law enforcement of certain registration requirements.

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

SEC. 101. ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM.

There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL COVERAGE.

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

1 (b) TREATMENT OF OTHER INDIVIDUALS.—The Sec-
2 retary may make eligible for benefits for health care serv-
3 ices under this Act other individuals not described in sub-
4 section (a), and regulate the eligibility of such individuals,
5 to ensure that every person in the United States has ac-
6 cess to health care. In regulating such eligibility, the Sec-
7 retary shall ensure that individuals are not allowed to
8 travel to the United States for the sole purpose of obtain-
9 ing health care items and services provided under the pro-
10 gram established under this Act.

11 **SEC. 103. FREEDOM OF CHOICE.**

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

15 **SEC. 104. NON-DISCRIMINATION.**

16 (a) IN GENERAL.—No person shall, on the basis of
17 race, color, national origin, age, disability, marital status,
18 citizenship status, primary language use, genetic condi-
19 tions, previous or existing medical conditions, religion, or
20 sex, including sex stereotyping, gender identity, sexual ori-
21 entation, and pregnancy and related medical conditions
22 (including termination of pregnancy), be excluded from
23 participation in or be denied the benefits of the program
24 established under this Act (except as expressly authorized
25 by this Act for purposes of enforcing eligibility standards

1 described in section 102), or be subject to any reduction
2 of benefits or other discrimination by any participating
3 provider (as defined in section 301), or any entity con-
4 ducting, administering, or funding a health program or
5 activity, including contracts of insurance, pursuant to this
6 Act.

7 (b) CLAIMS OF DISCRIMINATION.—

8 (1) IN GENERAL.—The Secretary shall establish
9 a procedure for adjudication of administrative com-
10 plaints alleging a violation of subsection (a).

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

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

23 (c) CONTINUED APPLICATION OF LAWS.—Nothing in
24 this title (or an amendment made by this title) shall be
25 construed to invalidate or otherwise limit any of the rights,

1 remedies, procedures, or legal standards available to indi-
2 viduals aggrieved under section 1557 of the Patient Pro-
3 tection and Affordable Care Act (42 U.S.C. 18116), title
4 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et
5 seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.
6 2000e et seq.), title IX of the Education Amendments of
7 1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-
8 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-
9 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing
10 in this title (or an amendment to this title) shall be con-
11 strued to supersede State laws that provide additional pro-
12 tections against discrimination on any basis described in
13 subsection (a).

14 **SEC. 105. ENROLLMENT.**

15 (a) IN GENERAL.—The Secretary shall provide a
16 mechanism for the enrollment of individuals eligible for
17 benefits under this Act. The mechanism shall—

18 (1) include a process for the automatic enroll-
19 ment of individuals at the time of birth in the
20 United States (or upon establishment of residency in
21 the United States);

22 (2) provide for the enrollment, as of the dates
23 described in section 106, of all individuals who are
24 eligible to be enrolled as of such dates, as applicable;
25 and

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

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

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

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

16 (b) COVERAGE FOR CERTAIN INDIVIDUALS.—
17 (1) IN GENERAL.—For any eligible individual
18 who—
19 (A) has not yet attained the age of 19 as
20 of the date that is 1 year after the date of the
21 enactment of this Act; or
22 (B) has attained the age of 55 as of the
23 date that is 1 year after the date of the enact-
24 ment of this Act,

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

(2) OPTION TO CONTINUE IN OTHER COVERAGE 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, and all contraceptive items approved by the Food and Drug Administration.

1 (5) Mental health and substance use treatment
2 services, including inpatient care.
3 (6) Laboratory and diagnostic services.
4 (7) Comprehensive reproductive care, including
5 abortion, contraception, and assistive reproductive
6 technology.
7 (8) Maternity and newborn care.
8 (9) Comprehensive gender affirming health
9 care.
10 (10) Oral health, audiology, and vision services.
11 (11) Rehabilitative and habilitative services and
12 devices.
13 (12) Emergency services and transportation.
14 (13) Early and periodic screening, diagnostic,
15 and treatment services, as described in sections
16 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and
17 1905(r) of the Social Security Act (42 U.S.C.
18 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B);
19 1396d(r)).
20 (14) Necessary transportation to receive health
21 care services for persons with disabilities, older indi-
22 viduals with functional limitations, or low-income in-
23 dividuals (as determined by the Secretary).
24 (15) Long-term care services and support (as
25 described in section 204).

1 (16) Hospice care.
2 (17) Services provided by a licensed marriage
3 and family therapist or a licensed mental health
4 counselor.
5 (18) Any service described in a preceding para-
6 graph that is furnished via telehealth, to the extent
7 practical.
8 (b) REVISION.—The Secretary shall, at least annu-
9 ally, and on a regular basis, evaluate whether the benefits
10 package should be improved to promote the health of bene-
11 ficiaries, account for changes in medical practice or new
12 information from medical research, or respond to other
13 relevant developments in health science, and shall make
14 recommendations to Congress regarding any such im-
15 provements. Such recommendations may not include a rec-
16 ommendation to eliminate any benefit.
17 (c) HEARINGS.—
18 (1) IN GENERAL.—The Committee on Energy
19 and Commerce and the Committee on Ways and
20 Means of the House of Representatives shall, not
21 less frequently than annually, hold a hearing on the
22 recommendations submitted by the Secretary under
23 subsection (b).
24 (2) EXERCISE OF RULEMAKING AUTHORITY.—
25 Paragraph (1) is enacted—

1 (A) as an exercise of rulemaking power of
2 the House of Representatives, and, as such,
3 shall be considered as part of the rules of the
4 House, and such rules shall supersede any other
5 rule of the House only to the extent that rule
6 is inconsistent therewith; and
7 (B) with full recognition of the constitu-
8 tional right of either House to change such
9 rules (so far as relating to the procedure in
10 such House) at any time, in the same manner,
11 and to the same extent as in the case of any
12 other rule of the House.
13 (d) COMPLEMENTARY AND INTEGRATIVE MEDI-
14 CINE.—
15 (1) IN GENERAL.—In carrying out subsection
16 (b), the Secretary shall consult with the persons de-
17 scribed in paragraph (2) with respect to—
18 (A) identifying specific complementary and
19 integrative medicine practices that are appro-
20 priate to include in the benefits package; and
21 (B) identifying barriers to the effective
22 provision and integration of such practices into
23 the delivery of health care, and identifying
24 mechanisms for overcoming such barriers.

1 (2) CONSULTATION.—In accordance with para-
2 graph (1), the Secretary shall consult with—
3 (A) the Director of the National Center for
4 Complementary and Integrative Health;
5 (B) the Commissioner of Food and Drugs;
6 (C) institutions of higher education, pri-
7 vate research institutes, and individual re-
8 searchers with extensive experience in com-
9 plementary and alternative medicine and the in-
10 tegration of such practices into the delivery of
11 health care;
12 (D) nationally recognized providers of com-
13 plementary and integrative medicine; and
14 (E) such other officials, entities, and indi-
15 viduals with expertise on complementary and
16 integrative medicine as the Secretary deter-
17 mines appropriate.
18 (e) STATES MAY PROVIDE ADDITIONAL BENE-
19 FITS.—Individual States may provide additional benefits
20 for the residents of such States, as determined by such
21 State, and may provide benefits to individuals not eligible
22 for benefits under this Act, at the expense of the State,
23 subject to the requirements specified in section 1102.

1 **SEC. 202. NO COST-SHARING; OTHER LIMITATIONS.**

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

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

9 (c) NO PRIOR AUTHORIZATION.—Benefits provided
10 under this Act shall be covered without any need for any
11 prior authorization determination and without any limita-
12 tion applied through the use of step therapy protocols.

13 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

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

18 (b) TREATMENT OF EXPERIMENTAL ITEMS AND
19 SERVICES AND DRUGS.—

20 (1) IN GENERAL.—In applying subsection (a),
21 the Secretary shall make national coverage deter-
22 minations with respect to items and services that are
23 experimental in nature. Such determinations shall be
24 consistent with the national coverage determination
25 process as defined in section 1869(f)(1)(B) of the
26 Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

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

7 (c) APPLICATION OF PRACTICE GUIDELINES.—

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

19 (A) exercised appropriate professional
20 judgment in accordance with the laws and re-
21 quirements of the State in which such item or
22 service is furnished in deviating from the guide-
23 line;

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

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

1 mination of medical necessity and appro-
2 priateness or nursing assessment;
3 (ii) in the best interests of the indi-
4 vidual; and
5 (iii) consistent with the individual's
6 wishes.

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

8 (a) IN GENERAL.—Subject to the other provisions of
9 this Act, individuals enrolled for benefits under this Act
10 are entitled to the following long-term services and sup-
11 ports and to have payment made by the Secretary to an
12 eligible provider for such services and supports if medically
13 necessary and appropriate and in accordance with the
14 standards established in this Act, for maintenance of
15 health or for care, services, diagnosis, treatment, or reha-
16 bilitation that is related to a medically determinable condi-
17 tion, whether physical or mental, of health, injury, or age
18 that—
19 (1) causes a functional limitation in performing
20 one or more activities of daily living; or
21 (2) requires a similar need of assistance in per-
22 forming instrumental activities of daily living.
23 (b) ELIGIBILITY.—An individual shall be eligible for
24 services and supports described in this section if such indi-

1 vidual has one or more medically determinable conditions
2 described in subsection (a).

3 (c) SERVICES AND SUPPORTS.—Long-term services
4 and supports under this section shall be tailored to an in-
5 dividual's needs, as determined through assessment, and
6 shall be defined by the Secretary to—

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

10 (2) provide coverage for a broad spectrum of
11 long-term services and supports, including for home
12 and community-based services and other care pro-
13 vided through non-institutional settings;

14 (3) provide coverage that meets the physical,
15 mental, and social needs of recipients while allowing
16 recipients their maximum possible autonomy and
17 their maximum possible civic, social, and economic
18 participation;

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

22 (5) unless an individual elects otherwise, ensure
23 that recipients will receive home and community
24 based long-term services and supports (as defined in

1 subsection (f)(4)), regardless of the individuals's
2 type or level of disability, service need, or age;
3 (6) be provided with the goal of enabling per-
4 sons with disabilities to receive services in the least
5 restrictive and most integrated setting appropriate
6 to the individual's needs;
7 (7) be provided in such a manner that allows
8 persons with disabilities to maintain their independ-
9 ence, self-determination, and dignity;
10 (8) provide long-term services and supports
11 that are of equal quality and equally accessible
12 across geographic regions; and
13 (9) ensure that long-term services and supports
14 provide recipient's the option of self-direction of
15 services from either the recipient or care coordina-
16 tors of the recipient's choosing.
17 (d) PUBLIC CONSULTATION.—In developing regula-
18 tions to implement this section, the Secretary shall consult
19 with an advisory commission on long-term services and
20 supports that includes—
21 (1) people with disabilities who use long-term
22 services and supports and older adults who use long-
23 term services and supports;
24 (2) representatives of people with disabilities
25 and representatives of older adults;

1 (3) groups that represent the diversity of the
2 population of people living with disabilities, including
3 racial, ethnic, national origin, primary language use,
4 age, sex, including gender identity and sexual ori-
5 entation, geographical, and socioeconomic diversity;
6 (4) providers of long-term services and sup-
7 ports, including family attendants and family care-
8 givers, and members of organized labor;
9 (5) disability rights organizations; and
10 (6) relevant academic institutions and research-
11 ers.
12 (e) BUDGETING AND PAYMENTS.—Budgeting and
13 payments for long-term services and supports provided
14 under this section shall be made in accordance with the
15 provisions under title VI.
16 (f) DEFINITIONS.—In this section:
17 (1) The term ''long-term services and supports''
18 means long-term care, treatment, maintenance, or
19 services needed to support the activities of daily liv-
20 ing and instrumental activities of daily living, includ-
21 ing home and community-based services and any ad-
22 ditional services and supports identified by the Sec-
23 retary to support people with disabilities to live,
24 work, and participate in their communities.

1 (2) The term ''activities of daily living'' means
2 basic personal everyday activities, including tasks
3 such as eating, toileting, grooming, dressing, bath-
4 ing, and transferring.

5 (3) The term ''instrumental activities of daily
6 living'' means activities related to living independ-
7 ently in the community, including meal planning and
8 preparation, managing finances, shopping for food,
9 clothing, and other essential items, performing es-
10 sential household chores, communicating by phone
11 or other media, and traveling around and partici-
12 pating in the community.

13 (4) The term ''home and community-based
14 services'' means the home and community-based
15 services that are coverable under subsections (c),
16 (d), (i), and (k) of section 1915 of the Social Secu-
17 rity Act (42 U.S.C. 1396n), and as defined by the
18 Secretary, including as defined in the home and
19 community-based services settings rule in sections
20 441.530 and 441.710 of title 42, Code of Federal
21 Regulations (or a successor regulation).

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS; WHISTLEBLOWER PROTECTIONS.

(a) IN GENERAL.—An individual or other entity furnishing any covered item or service under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the items or services under section 302;

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

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

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between the Secretary and a provider shall provide at least for the following:

(A) Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 104(a).

1 Nothing in this subparagraph shall be con-
2 strued as requiring the provision of a type or
3 class of items or services that are outside the
4 scope of the provider's normal practice.
5 (B) No charge will be made to any enrolled
6 individual for any covered items or services
7 other than for payment authorized by this Act.
8 (C) The provider agrees to furnish such in-
9 formation as may be reasonably required by the
10 Secretary, in accordance with uniform reporting
11 standards established under section 401(b)(1),
12 for—
13 (i) quality review by designated enti-
14 ties;
15 (ii) making payments under this Act,
16 including the examination of records as
17 may be necessary for the verification of in-
18 formation on which such payments are
19 based;
20 (iii) statistical or other studies re-
21 quired for the implementation of this Act;
22 and
23 (iv) such other purposes as the Sec-
24 retary may specify.

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

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

16 (F) In the case of an institutional provider
17 paid pursuant to section 611, the provider
18 agrees to submit information and any other re-
19 quired supporting documentation as may be
20 reasonably required by the Secretary within 30
21 days after the date of providing such items and
22 services and in accordance with the uniform re-
23 porting standards established under section
24 401(b)(1), including information on a quarterly
25 basis that—

1 (i) relates to the provision of covered
2 items and services; and
3 (ii) describes items and services fur-
4 nished with respect to specific individuals.
5 (G) In the case of a provider that receives
6 payment for items and services furnished under
7 this Act based on diagnosis-related coding, pro-
8 cedure coding, or other coding system or data,
9 the provider agrees—
10 (i) to disclose to the Secretary any
11 system or index of coding or classifying pa-
12 tient symptoms, diagnoses, clinical inter-
13 ventions, episodes, or procedures that such
14 provider utilizes for global budget negotia-
15 tions under title VI or for meeting any
16 other payment, documentation, or data col-
17 lection requirements under this Act; and
18 (ii) not to use any such system or
19 index to establish financial incentives or
20 disincentives for health care professionals,
21 or that is proprietary, interferes with the
22 medical or nursing process, or is designed
23 to increase the amount or number of pay-
24 ments.

1 (H) The provider complies with the duty of
2 provider ethics and reporting requirements de-
3 scribed in paragraph (2).
4 (I) In the case of a provider that is not an
5 individual, the provider agrees that no board
6 member, executive, or administrator of such
7 provider receives compensation from, owns
8 stock or has other financial investments in, or
9 serves as a board member of any entity that
10 contracts with or provides items or services, in-
11 cluding pharmaceutical products and medical
12 devices or equipment, to such provider.
13 (2) PROVIDER DUTY OF ETHICS.—Each health
14 care provider, including institutional providers, has a
15 duty to advocate for and to act in the exclusive in-
16 terest of each individual under the care of such pro-
17 vider according to the applicable legal standard of
18 care, such that no financial interest or relationship
19 impairs any health care provider's ability to furnish
20 necessary and appropriate care to such individual.
21 To implement the duty established in this para-
22 graph, the Secretary shall—
23 (A) promulgate reasonable reporting rules
24 to evaluate participating provider compliance
25 with this paragraph;

1 (B) prohibit participating providers,
2 spouses, and immediate family members of par-
3 ticipating providers, from accepting or entering
4 into any arrangement for any bonus, incentive
5 payment, profit-sharing, or compensation based
6 on patient utilization or based on financial out-
7 comes of any other provider or entity; and
8 (C) prohibit participating providers or any
9 board member or representative of such pro-
10 vider from serving as board members for or re-
11 ceiving any compensation, stock, or other finan-
12 cial investment in an entity that contracts with
13 or provides items or services (including pharma-
14 ceutical products and medical devices or equip-
15 ment) to such provider.
16 (3) TERMINATION OF PARTICIPATION AGREE-
17 MENT.—
18 (A) IN GENERAL.—Participation agree-
19 ments may be terminated, with appropriate no-
20 tice—
21 (i) by the Secretary for failure to meet
22 the requirements of this Act;
23 (ii) in accordance with the provisions
24 described in section 411; or
25 (iii) by a provider.

1 (B) TERMINATION PROCESS.—Providers
2 shall be provided notice and a reasonable oppor-
3 tunity to correct deficiencies before the Sec-
4 retary terminates an agreement unless a more
5 immediate termination is required for public
6 safety or similar reasons.
7 (C) PROVIDER PROTECTIONS.—
8 (i) PROHIBITION.—The Secretary may
9 not terminate a participation agreement or
10 in any other way discriminate against, or
11 cause to be discriminated against, any cov-
12 ered provider or authorized representative
13 of the provider, on account of such pro-
14 vider or representative—
15 (I) providing, causing to be pro-
16 vided, or being about to provide or
17 cause to be provided to the provider,
18 the Federal Government, or the attor-
19 ney general of a State information re-
20 lating to any violation of, or any act
21 or omission the provider or represent-
22 ative reasonably believes to be a viola-
23 tion of, any provision of this title (or
24 an amendment made by this title);

1 (II) testifying or being about to
2 testify in a proceeding concerning
3 such violation;
4 (III) assisting or participating, or
5 being about to assist or participate, in
6 such a proceeding; or
7 (IV) objecting to, or refusing to
8 participate in, any activity, policy,
9 practice, or assigned task that the
10 provider or representative reasonably
11 believes to be in violation of any provi-
12 sion of this Act (including any amend-
13 ment made by this Act), or any order,
14 rule, regulation, standard, or ban
15 under this Act (including any amend-
16 ment made by this Act).
17 (ii) COMPLAINT PROCEDURE.—A pro-
18 vider or representative who believes that he
19 or she has been discriminated against in
20 violation of this section may seek relief in
21 accordance with the procedures, notifica-
22 tions, burdens of proof, remedies, and stat-
23 utes of limitation set forth in section
24 2087(b) of title 15, United States Code.
25 (c) WHISTLEBLOWER PROTECTIONS.—

1 (1) RETALIATION PROHIBITED.—No person
2 may discharge or otherwise discriminate against any
3 employee because the employee or any person acting
4 pursuant to a request of the employee—
5 (A) notified the Secretary or the employ-
6 ee's employer of any alleged violation of this
7 title, including communications related to car-
8 rying out the employee's job duties;
9 (B) refused to engage in any practice made
10 unlawful by this title, if the employee has iden-
11 tified the alleged illegality to the employer;
12 (C) testified before or otherwise provided
13 information relevant for Congress or for any
14 Federal or State proceeding regarding any pro-
15 vision (or proposed provision) of this title;
16 (D) commenced, caused to be commenced,
17 or is about to commence or cause to be com-
18 menced a proceeding under this title;
19 (E) testified or is about to testify in any
20 such proceeding; or
21 (F) assisted or participated or is about to
22 assist or participate in any manner in such a
23 proceeding or in any other manner in such a
24 proceeding or in any other action to carry out
25 the purposes of this title.

1 (2) ENFORCEMENT ACTION.—Any employee
2 covered by this section who alleges discrimination by
3 an employer in violation of paragraph (1) may bring
4 an action, subject to the statute of limitations in the
5 anti-retaliation provisions of the False Claims Act
6 and the rules and procedures, legal burdens of proof,
7 and remedies applicable under the employee protec-
8 tions provisions of the Surface Transportation As-
9 sistance Act.
10 (3) APPLICATION.—
11 (A) Nothing in this subsection shall be
12 construed to diminish the rights, privileges, or
13 remedies of any employee under any Federal or
14 State law or regulation, including the rights
15 and remedies against retaliatory action under
16 the False Claims Act (31 U.S.C. 3730(h)), or
17 under any collective bargaining agreement. The
18 rights and remedies in this section may not be
19 waived by any agreement, policy, form, or con-
20 dition of employment.
21 (B) Nothing in this subsection shall be
22 construed to preempt or diminish any other
23 Federal or State law or regulation against dis-
24 crimination, demotion, discharge, suspension,
25 threats, harassment, reprimand, retaliation, or

any other manner of discrimination, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)).

(4) DEFINITIONS.—In this subsection:

(A) EMPLOYER.—The term ''employer'' means any person engaged in profit or nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and subject to liability for violating the provisions of this Act.

(B) EMPLOYEE.—The term ''employee'' means any individual performing activities under this Act on behalf of an employer.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to furnish covered items and services under this Act if the provider is licensed or certified to furnish such items and services in the State in which the individual receiving such items or services is located and meets—

1 (1) the requirements of such State's law to fur-
2 nish such items and services; and

3 (2) applicable requirements of Federal law to
4 furnish such items and services.

5 (b) LIMITATION.—An entity or provider shall not be
6 qualified to furnish covered items and services under this
7 Act if the entity or provider provides no items and services
8 directly to individuals, including—

9 (1) entities or providers that contract with
10 other entities or providers to provide such items and
11 services; and

12 (2) entities that are currently approved to co-
13 ordinate care plans under the Medicare Advantage
14 program established in part C of title XVIII of the
15 Social Security Act (42 U.S.C. 1851 et seq.) but do
16 not directly provide items and services of such care
17 plans.

18 (c) MINIMUM PROVIDER STANDARDS.—

19 (1) IN GENERAL.—The Secretary shall estab-
20 lish, evaluate, and update national minimum stand-
21 ards to ensure the quality of items and services pro-
22 vided under this Act and to monitor efforts by
23 States to ensure the quality of such items and serv-
24 ices. A State may establish additional minimum

1 standards which providers shall meet with respect to
2 items and services provided in such State.
3 (2) NATIONAL MINIMUM STANDARDS.—The
4 Secretary shall establish national minimum stand-
5 ards under paragraph (1) for institutional providers
6 of services and individual health care practitioners.
7 Except as the Secretary may specify in order to
8 carry out this Act, a hospital, skilled nursing facility,
9 or other institutional provider of services shall meet
10 standards applicable to such a provider under the
11 Medicare program under title XVIII of the Social
12 Security Act (42 U.S.C. 1395 et seq.). Such stand-
13 ards also may include, where appropriate, elements
14 relating to—
15 (A) adequacy and quality of facilities;
16 (B) mandatory minimum safe registered
17 nurse-to-patient staffing ratios and optimal
18 staffing levels for physicians and other health
19 care practitioners;
20 (C) training and competence of personnel
21 (including requirements related to the number
22 of or type of required continuing education
23 hours);
24 (D) comprehensiveness of service;
25 (E) continuity of service;

1 (F) patient waiting time, access to serv-
2 ices, and preferences; and
3 (G) performance standards, including orga-
4 nization, facilities, structure of services, effi-
5 ciency of operation, and outcome in palliation,
6 improvement of health, stabilization, cure, or
7 rehabilitation.
8 (3) TRANSITION IN APPLICATION.—If the Sec-
9 retary provides for additional requirements for pro-
10 viders under this subsection, any such additional re-
11 quirement shall be implemented in a manner that
12 provides for a reasonable period during which a pre-
13 viously qualified provider is permitted to meet such
14 an additional requirement.
15 (4) ABILITY TO PROVIDE SERVICES.—With re-
16 spect to any entity or provider certified to provide
17 items and services described in section 201(a)(7),
18 the Secretary may not prohibit such entity or pro-
19 vider from participating for reasons other than such
20 entity's or provider's ability to provide such items
21 and services.
22 (d) FEDERAL PROVIDERS.—Any provider qualified to
23 provide health care items and services through the Depart-
24 ment of Veterans Affairs, the Indian Health Service, or
25 the uniformed services (with respect to the direct care

1 component of the TRICARE Program) is a qualifying pro-
2 vider under this section with respect to any individual who
3 qualifies for such items and services under applicable Fed-
4 eral law.

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

6 (a) IN GENERAL.—This section shall apply beginning
7 2 years after the date of the enactment of this Act.

8 (b) PARTICIPATING PROVIDERS.—

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

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

23 (A) the contract and provider meet the re-
24 quirements specified in paragraphs (3) and (4),
25 respectively;

1 (B) such item or service is not payable or
2 available under this Act; and
3 (C) the provider receives—
4 (i) no reimbursement under this Act
5 directly or indirectly for such item or serv-
6 ice, and
7 (ii) receives no amount for such item
8 or service from an organization which re-
9 ceives reimbursement for such items or
10 service under this Act directly or indirectly.
11 (3) CONTRACT REQUIREMENTS.—Any contract
12 to provide items and services described in paragraph
13 (2) shall—
14 (A) be in writing and signed by the indi-
15 vidual (or authorized representative of the indi-
16 vidual) receiving the item or service before the
17 item or service is furnished pursuant to the
18 contract;
19 (B) not be entered into at a time when the
20 individual is facing an emergency health care
21 situation; and
22 (C) clearly indicate to the individual receiv-
23 ing such items and services that by signing
24 such a contract the individual—

1 (i) agrees not to submit a claim (or to
2 request that the provider submit a claim)
3 under this Act for such items or services;
4 (ii) agrees to be responsible for pay-
5 ment of such items or services and under-
6 stands that no reimbursement will be pro-
7 vided under this Act for such items or
8 services;
9 (iii) acknowledges that no limits under
10 this Act apply to amounts that may be
11 charged for such items or services; and
12 (iv) acknowledges that the provider is
13 providing services outside the scope of the
14 program under this Act.
15 (4) AFFIDAVIT.—A participating provider who
16 enters into a contract described in paragraph (2)
17 shall have in effect during the period any item or
18 service is to be provided pursuant to the contract an
19 affidavit that shall—
20 (A) identify the provider who is to furnish
21 such noncovered item or service, and be signed
22 by such provider;
23 (B) state that the provider will not submit
24 any claim under this Act for any noncovered

1 item or service provided to any individual en-
2 rolled under this Act; and
3 (C) be filed with the Secretary no later
4 than 10 days after the first contract to which
5 such affidavit applies is entered into.
6 (5) ENFORCEMENT.—If a provider signing an
7 affidavit described in paragraph (4) knowingly and
8 willfully submits a claim under this title for any item
9 or service provided or receives any reimbursement or
10 amount for any such item or service provided pursu-
11 ant to a private contract described in paragraph (2)
12 with respect to such affidavit—
13 (A) any contract described in paragraph
14 (2) shall be null and void;
15 (B) no payment shall be made under this
16 title for any item or service furnished by the
17 provider during the 2-year period beginning on
18 the date the affidavit was signed; and
19 (C) any payment received under this title
20 for any item or service furnished during such
21 period shall be remitted.
22 (6) PRIVATE CONTRACTS FOR INELIGIBLE INDI-
23 VIDUALS.—An institutional or individual provider
24 with an agreement in effect under section 301 may
25 bill or enter into a private contract with any indi-

1 vidual ineligible for benefits under the Act for any
2 item or service.
3 (c) NONPARTICIPATING PROVIDERS.—
4 (1) PRIVATE CONTRACTS FOR COVERED ITEMS
5 AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-
6 stitutional or individual provider with no agreement
7 in effect under section 301 may bill or enter into
8 any private contract with any individual eligible for
9 benefits under the Act for any item or service that
10 is a benefit under this Act described in title II only
11 if the contract and provider meet the requirements
12 specified in paragraphs (2) and (3), respectively.
13 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-
14 TRACT.—Any contract to provide items and services
15 described in paragraph (1) shall—
16 (A) be in writing and signed by the indi-
17 vidual (or authorized representative of the indi-
18 vidual) receiving the item or service before the
19 item or service is furnished pursuant to the
20 contract;
21 (B) not be entered into at a time when the
22 individual is facing an emergency health care
23 situation; and

1 (C) clearly indicate to the individual receiv-
2 ing such items and services that by signing
3 such a contract the individual—
4 (i) acknowledges that the individual
5 has the right to have such items or services
6 provided by other providers for whom pay-
7 ment would be made under this Act;
8 (ii) agrees not to submit a claim (or
9 to request that the provider submit a
10 claim) under this Act for such items or
11 services even if such items or services are
12 otherwise covered by this Act;
13 (iii) agrees to be responsible for pay-
14 ment of such items or services and under-
15 stands that no reimbursement will be pro-
16 vided under this Act for such items or
17 services;
18 (iv) acknowledges that no limits under
19 this Act apply to amounts that may be
20 charged for such items or services; and
21 (v) acknowledges that the provider is
22 providing services outside the scope of the
23 program under this Act.
24 (3) AFFIDAVIT.—A provider who enters into a
25 contract described in paragraph (1) shall have in ef-

1 fect during the period any item or service is to be
2 provided pursuant to the contract an affidavit that
3 shall—
4 (A) identify the provider who is to furnish
5 such covered item or service, and be signed by
6 such provider;
7 (B) state that the provider will not submit
8 any claim under this Act for any covered item
9 or service provided to any individual enrolled
10 under this Act during the 2-year period begin-
11 ning on the date the affidavit is signed; and
12 (C) be filed with the Secretary no later
13 than 10 days after the first contract to which
14 such affidavit applies is entered into.
15 (4) ENFORCEMENT.—If a provider signing an
16 affidavit described in paragraph (3) knowingly and
17 willfully submits a claim under this title for any item
18 or service provided or receives any reimbursement or
19 amount for any such item or service provided pursu-
20 ant to a private contract described in paragraph (1)
21 with respect to such affidavit—
22 (A) any contract described in paragraph
23 (1) shall be null and void; and
24 (B) no payment shall be made under this
25 title for any item or service furnished by the

1 provider during the 2-year period beginning on
2 the date the affidavit was signed.
3 (5) PRIVATE CONTRACTS FOR NONCOVERED
4 ITEMS AND SERVICES FOR ANY INDIVIDUAL.—An in-
5 stitutional or individual provider with no agreement
6 in effect under section 301 may bill or enter into a
7 private contract with any individual for a item or
8 service that is not a benefit under this Act.

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;

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

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

1 (J) encouraging States to develop regional
2 planning mechanisms; and
3 (K) any other regulations necessary to
4 carry out the purposes of this Act.
5 (2) REGULATIONS.—Regulations authorized by
6 this Act shall be issued by the Secretary in accord-
7 ance with section 553 of title 5, United States Code.
8 (3) ACCESSIBILITY.—The Secretary shall have
9 the obligation to ensure the timely and accessible
10 provision of items and services that all eligible indi-
11 viduals are entitled to under this Act.
12 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-
13 PORT; STUDIES.—
14 (1) UNIFORM REPORTING STANDARDS.—
15 (A) IN GENERAL.—The Secretary shall es-
16 tablish uniform State reporting requirements
17 and national standards to ensure an adequate
18 national database containing information per-
19 taining to health services practitioners, ap-
20 proved providers, the costs of facilities and
21 practitioners providing items and services, the
22 quality of such items and services, the outcomes
23 of such items and services, and the equity of
24 health among population groups. Such database
25 shall include, to the maximum extent feasible

1 without compromising patient privacy, health
2 outcome measures used under this Act, and to
3 the maximum extent feasible without excessively
4 burdening providers, a description of the stand-
5 ards and qualifications, levels of finding, and
6 methods described in subparagraphs (D)
7 through (F) of subsection (a)(1).

8 (B) REQUIRED DATA DISCLOSURES.—In
9 establishing reporting requirements and stand-
10 ards under subparagraph (A), the Secretary
11 shall require a provider with an agreement in
12 effect under section 301 to disclose to the Sec-
13 retary, in a time and manner specified by the
14 Secretary, the following (as applicable to the
15 type of provider):

16 (i) Any data the provider is required
17 to report or does report to any State or
18 local agency, or, as of January 1, 2019, to
19 the Secretary or any entity that is part of
20 the Department of Health and Human
21 Services, except data that are required
22 under the programs terminated in section
23 903.

24 (ii) Annual financial data that in-
25 cludes information on employees (including

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

14 (C) REPORTS.—The Secretary shall regu-
15 larly analyze information reported to the Sec-
16 retary and shall define rules and procedures to
17 allow researchers, scholars, health care pro-
18 viders, and others to access and analyze data
19 for purposes consistent with quality and out-
20 comes research, without compromising patient
21 privacy.

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

1 (A) The status of implementation of the
2 Act.
3 (B) Enrollment under this Act.
4 (C) Benefits under this Act.
5 (D) Expenditures and financing under this
6 Act.
7 (E) Cost-containment measures and
8 achievements under this Act.
9 (F) Quality assurance.
10 (G) Health care utilization patterns, in-
11 cluding any changes attributable to the pro-
12 gram.
13 (H) Changes in the per-capita costs of
14 health care.
15 (I) Differences in the health status of the
16 populations of the different States, including by
17 racial, ethnic, national origin, primary language
18 use, age, disability, sex, including gender iden-
19 tity and sexual orientation, geographical, and
20 income characteristics;
21 (J) Progress on quality and outcome meas-
22 ures, and long-range plans and goals for
23 achievements in such areas.
24 (K) Plans for improving service to medi-
25 cally underserved populations.

1 (L) Transition problems as a result of im-
2 plementation of this Act.
3 (M) Opportunities for improvements under
4 this Act.
5 (3) STATISTICAL ANALYSES AND OTHER STUD-
6 IES.—The Secretary may, either directly or by con-
7 tract—
8 (A) make statistical and other studies, on
9 a nationwide, regional, State, or local basis, of
10 any aspect of the operation of this Act;
11 (B) develop and test methods of delivery of
12 items and services as the Secretary may con-
13 sider necessary or promising for the evaluation,
14 or for the improvement, of the operation of this
15 Act; and
16 (C) develop methodological standards for
17 policymaking.
18 (c) AUDITS.—
19 (1) IN GENERAL.—The Comptroller General of
20 the United States shall conduct an audit of the De-
21 partment of Health and Human Services every fifth
22 fiscal year following the effective date of this Act to
23 determine the effectiveness of the program in car-
24 rying out the duties under subsection (a).

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

5 **SEC. 402. CONSULTATION.**

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

21 **SEC. 403. REGIONAL ADMINISTRATION.**

22 (a) COORDINATION WITH REGIONAL OFFICES.—The
23 Secretary shall establish and maintain regional offices for
24 purposes of carrying out the duties specified in subsection
25 (c) and promoting adequate access to, and efficient use

1 of, tertiary care facilities, equipment, and services by indi-
2 viduals enrolled under this Act. Wherever possible, the
3 Secretary shall incorporate regional offices of the Centers
4 for Medicare & Medicaid Services for this purpose.

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

7 (1) one regional director appointed by the Sec-
8 retary;

9 (2) one deputy director appointed by the re-
10 gional director to represent the Indian and Alaska
11 Native tribes in the region, if any; and

12 (3) one deputy direction appointed by the re-
13 gional director to oversee long-term services and
14 supports.

15 (c) REGIONAL OFFICE DUTIES.—Each regional di-
16 rector shall—

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

23 (2) recommend any changes in provider reim-
24 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

(3) submit annual reports to Congress and the Secretary that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

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

The following sections of the Social Security Act shall 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 mechanisms that discriminate against people with
18 disabilities is prohibited for use in any value or cost-
19 effectiveness assessments. The Center shall consider
20 the evidentiary basis for the standard, and the valid-
21 ity, reliability, and feasibility of measuring the
22 standard.

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

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

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

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

18 (a) EVALUATING DATA COLLECTION AP-
19 PROACHES.—The Center shall evaluate approaches for the
20 collection of data under this Act, to be performed in con-
21 junction with existing quality reporting requirements and
22 programs under this Act, that allow for the ongoing, accu-
23 rate, and timely collection of data on disparities in health
24 care services and performance on the basis of race, eth-
25 nicity, national origin, primary language use, age, dis-

1 ability, sex (including gender identity and sexual orienta-
2 tion), geography, or socioeconomic status. In conducting
3 such evaluation, the Center shall consider the following ob-
4 jectives:

5 (1) Protecting patient privacy.

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

9 (3) Improving data on race, ethnicity, national
10 origin, primary language use, age, disability, sex (in-
11 cluding gender identity and sexual orientation), ge-
12 ography, and socioeconomic status.

13 (b) REPORTS TO CONGRESS.—

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

21 (A) identify approaches (including defining
22 methodologies) for identifying and collecting
23 and evaluating data on health care disparities
24 on the basis of race, ethnicity, national origin,
25 primary language use, age, disability, sex (in-

1 cluding gender identity and sexual orientation),
2 geography, or socioeconomic status under the
3 Medicare for All Program; and
4 (B) include recommendations on the most
5 effective strategies and approaches to reporting
6 quality measures, as appropriate, on the basis
7 of race, ethnicity, national origin, primary lan-
8 guage use, age, disability, sex (including gender
9 identity and sexual orientation), geography, or
10 socioeconomic status.
11 (2) REPORT ON DATA ANALYSES.—Not later
12 than 4 years after the submission of the report
13 under subsection (b)(1), and every 4 years there-
14 after, the Center shall submit to Congress and the
15 Secretary a report that includes recommendations
16 for improving the identification of health care dis-
17 parities based on the analyses of data collected
18 under subsection (c).
19 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
20 later than 2 years after the date on which benefits first
21 become available as described in section 106(a), the Sec-
22 retary shall implement the approaches identified in the re-
23 port submitted under subsection (b)(1) for the ongoing,
24 accurate, and timely collection and evaluation of data on
25 health care disparities on the basis of race, ethnicity, na-

tional origin, primary language use, age, disability, sex (including gender identity and sexual orientation), 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.

(D) Quality assessment activities under title V.

1 (E) Health professional education expenditures.
3 (F) Administrative costs, including costs related to the operation of regional offices.
5 (G) A reserve fund.
6 (H) Prevention and public health activities.
7 (3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the funds received for purposes of carrying out this Act among the components described in paragraph (2) in a manner that ensures—
12 (A) that the operating budget allows for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations;
16 (B) that the special projects budget is sufficient to meet the health care needs within areas described in paragraph (2)(C) through the construction, renovation, and staffing of health care facilities in a reasonable timeframe;
21 (C) a fair allocation for quality assessment activities; and
23 (D) that the health professional education expenditure component is sufficient to provide for the amount of health professional education

1 expenditures sufficient to meet the need for cov-
2 ered health care services.

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

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

14 (A) payments to institutional providers
15 pursuant to section 611; and

16 (B) payments to individual providers pur-
17 suant to section 612.

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

21 (A) the construction or renovation of
22 health care facilities, excluding congregate or
23 segregated facilities for individuals with disabil-
24 ities who receive long-term care services and
25 support; and

1 (B) major equipment purchases.

2 (7) SPECIAL PROJECTS BUDGET.—The special
3 projects budget described in paragraph (2)(C) shall
4 be used for the purposes of allocating funds for the
5 construction of new facilities, major equipment pur-
6 chases, and staffing in rural or medically under-
7 served areas (as defined in section 330(b)(3) of the
8 Public Health Service Act (42 U.S.C. 254b(b)(3))),
9 including areas designated as health professional
10 shortage areas (as defined in section 332(a) of the
11 Public Health Service Act (42 U.S.C. 254e(a))), and
12 to address health disparities, including racial, ethnic,
13 national origin, primary language use, age, dis-
14 ability, sex (including gender identity and sexual ori-
15 entation), geography, or socioeconomic health dis-
16 parities.

17 (8) TEMPORARY WORKER ASSISTANCE.—

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

1 who may be affected by the implementation of
2 this Act and who may experience economic dis-
3 location as a result of the implementation of
4 this Act.

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

10 (9) RESERVE FUND.—The reserve fund de-
11 scribed in paragraph (2)(G) shall be used to respond
12 to the costs of an epidemic, pandemic, natural dis-
13 aster, or other such health emergency, or market-
14 shift adjustments related to patient volume.

15 (10) SUPPLEMENTAL INDIAN HEALTH SERVICE
16 ALLOCATION.—The Secretary shall annually deter-
17 mine the need to provide an allotment of supple-
18 mental funds to Indian Health Services, including
19 payments to providers, capital expenditures, special
20 projects, health professional education, administra-
21 tive expenses, and prevention and public health ac-
22 tivities.

23 (b) DEFINITIONS.—In this section:

24 (1) CAPITAL EXPENDITURES.—The term ''cap-
25 ital expenditures'' means expenses for the purchase,

1 lease, construction, or renovation of capital facilities
2 and for major equipment.
3 (2) HEALTH PROFESSIONAL EDUCATION EX-
4 PENDITURES.—The term ''health professional edu-
5 cation expenditures'' means expenditures in hospitals
6 and other health care facilities to cover costs associ-
7 ated with teaching and related research activities, in-
8 cluding the impact of workforce diversity on patient
9 outcomes.

10 Subtitle B—Payments to Providers

11 SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS
12 BASED ON GLOBAL BUDGETS.

13 (a) IN GENERAL.—Not later than the beginning of
14 each fiscal quarter during which an institutional provider
15 of care (including hospitals, skilled nursing facilities, Fed-
16 erally qualified health centers, and independent dialysis fa-
17 cilities) is to furnish items and services under this Act,
18 the Secretary shall pay to such institutional provider a
19 lump sum in accordance with the succeeding provisions of
20 this subsection and consistent with the following:
21 (1) PAYMENT IN FULL.—Such payment shall be
22 considered as payment in full for all operating ex-
23 penses for items and services furnished under this
24 Act, whether inpatient or outpatient, by such pro-
25 vider for such quarter, including outpatient or any

1 other care provided by the institutional provider or
2 provided by any health care provider who provided
3 items and services pursuant to an agreement paid
4 through the global budget as described in paragraph
5 (3).

6 (2) QUARTERLY REVIEW.—The regional direc-
7 tor, on a quarterly basis, shall review whether re-
8 quirements of the institutional provider's participa-
9 tion agreement and negotiated global budget have
10 been performed and shall determine whether adjust-
11 ments to such institutional provider's payment are
12 warranted. This review shall include consideration
13 for additional funding necessary for unanticipated
14 items and services for individuals with complex med-
15 ical needs or market-shift adjustments related to pa-
16 tient volume. The review shall also include an as-
17 sessment of any adjustments made to ensure that
18 accuracy and need for adjustment was appropriate.

19 (3) AGREEMENTS FOR SALARIED PAYMENTS
20 FOR CERTAIN PROVIDERS.—Certain group practices
21 and other health care providers, as determined by
22 the Secretary, with agreements to provide items and
23 services at a specified institutional provider paid a
24 global budget under this subsection may elect to be
25 paid through such institutional provider's global

1 budget in lieu of payment under section 612 of this
2 title. Any—
3 (A) individual health care professional of
4 such group practice or other provider receiving
5 payment through an institutional provider's
6 global budget shall be paid on a salaried basis
7 that is equivalent to salaries or other compensa-
8 tion rates negotiated for individual health care
9 professionals of such institutional provider; and
10 (B) any group practice or other health care
11 provider that receives payment through an in-
12 stitutional provider global budget under this
13 paragraph shall be subject to the same report-
14 ing and disclosure requirements of the institu-
15 tional provider.
16 (4) INTERIM ADJUSTMENTS.—The regional di-
17 rector shall consider a petition for adjustment of any
18 payment under this section filed by an institutional
19 provider at any time based on the following:
20 (A) Factors that led to increased costs for
21 the institutional provider that can reasonably be
22 considered to be unanticipated and out of the
23 control of the institutional provider, such as—
24 (i) natural disasters;

1 (ii) outbreaks of epidemics or infec-
2 tious diseases;
3 (iii) unexpected facility or equipment
4 repairs or purchases;
5 (iv) significant and unexpected in-
6 creases in pharmaceutical or medical device
7 prices; and
8 (v) unanticipated increases in complex
9 or high-cost patients or care needs.
10 (B) Changes in Federal or State law that
11 result in a change in costs.
12 (C) Reasonable increases in labor costs, in-
13 cluding salaries and benefits, and changes in
14 collective bargaining agreements, prevailing
15 wage, or local law.
16 (b) PAYMENT AMOUNT.—
17 (1) IN GENERAL.—The amount of each pay-
18 ment to a provider described in subsection (a) shall
19 be determined before the start of each fiscal year
20 through negotiations between the provider and the
21 regional director with jurisdiction over such pro-
22 vider. Such amount shall be based on factors speci-
23 fied in paragraph (2).

1 (2) PAYMENT FACTORS.—Payments negotiated
2 pursuant to paragraph (1) shall take into account,
3 with respect to a provider—
4 (A) the historical volume of services pro-
5 vided for each item and services in the previous
6 3-year period;
7 (B) the actual expenditures of such pro-
8 vider in such provider's most recent cost report
9 under title XVIII of the Social Security Act for
10 each item and service compared to—
11 (i) such expenditures for other institu-
12 tional providers in the director's jurisdic-
13 tion; and
14 (ii) normative payment rates estab-
15 lished under comparative payment rate
16 systems, including any adjustments, for
17 such items and services;
18 (C) projected changes in the volume and
19 type of items and services to be furnished;
20 (D) wages for employees, including any
21 necessary increases for mandatory minimum
22 safe registered nurse-to-patient ratios and opti-
23 mal staffing levels for physicians and other
24 health care workers;

1 (E) the provider's maximum capacity to
2 provide items and services;
3 (F) education and prevention programs;
4 (G) permissible adjustment to the pro-
5 vider's operating budget due to factors such
6 as—
7 (i) an increase in primary or specialty
8 care access;
9 (ii) efforts to decrease health care dis-
10 parities in rural or medically underserved
11 areas;
12 (iii) a response to emergent epidemic
13 conditions;
14 (iv) an increase in complex or high-
15 cost patients or care needs; or
16 (v) proposed new and innovative pa-
17 tient care programs at the institutional
18 level;
19 (H) whether the provider is located in a
20 high social vulnerability index community, ZIP
21 Code, or census track, or is a minority-serving
22 provider; and
23 (I) any other factor determined appro-
24 priate by the Secretary.

1 (3) LIMITATION.—Payment amounts negotiated
2 pursuant to paragraph (1) may not—
3 (A) take into account capital expenditures
4 of the provider or any other expenditure not di-
5 rectly associated with the provision of items and
6 services by the provider to an individual;
7 (B) be used by a provider for capital ex-
8 penditures or such other expenditures;
9 (C) exceed the provider's capacity to pro-
10 vide care under this Act; or
11 (D) be used to pay or otherwise com-
12 pensate any board member, executive, or ad-
13 ministrator of the institutional provider who
14 has any interest or relationship prohibited
15 under section 301(b)(2) of this Act or disclosed
16 under section 301 of this Act.
17 (4) 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 (5) REGIONAL NEGOTIATIONS PERMITTED.—
25 Subject to section 614, a regional director may nego-

1 tiate changes to an institutional provider's global
2 budget, including any adjustments to address un-
3 foreseen market-shifts related to patient volume.
4 (c) BASELINE RATES AND ADJUSTMENTS.—
5 (1) IN GENERAL.—The Secretary shall use ex-
6 isting prospective payment systems under title
7 XVIII of the Social Security Act to serve as the
8 comparative payment rate system in global budget
9 negotiations described in subsection (b). The Sec-
10 retary shall update such comparative payment rate
11 systems annually.
12 (2) SPECIFICATIONS.—In developing the com-
13 parative payment rate system, the Secretary shall
14 use only the operating base payment rates under
15 each such prospective payment systems with applica-
16 ble adjustments.
17 (3) LIMITATION.—The comparative rate system
18 established under this subsection shall not include
19 the value-based payment adjustments and the cap-
20 ital expenses base payment rates that may be in-
21 cluded in such a prospective payment system.
22 (4) INITIAL YEAR.—In the first year that global
23 budget payments under this Act are available to in-
24 stitutional providers and for purposes of selecting a
25 comparative payment rate system used during initial

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

11 (d) OPERATING EXPENSES.—For purposes of this
12 title, ''operating expenses'' of a provider include the fol-
13 lowing:

14 (1) The cost of all items and services associated
15 with the provision of inpatient care and outpatient
16 care, including the following:

17 (A) Wages and salary costs for physicians,
18 nurses, and other health care practitioners em-
19 ployed by an institutional provider, including
20 mandatory minimum safe registered nurse-to-
21 patient staffing ratios and optimal staffing lev-
22 els for physicians and other healthcare workers.

23 (B) Wages and salary costs for all ancil-
24 lary staff and services.

1 (C) Costs of all pharmaceutical products
2 administered by health care clinicians at the in-
3 stitutional provider's facilities or through serv-
4 ices provided in accordance with State licensing
5 laws or regulations under which the institu-
6 tional provider operates.

7 (D) Costs for infectious disease response
8 preparedness, including maintenance of a 1-
9 year or 365-day stockpile of personal protective
10 equipment, occupational testing and surveil-
11 lance, medical services for occupational infec-
12 tious disease exposure, and contact tracing.

13 (E) Purchasing and maintenance of med-
14 ical devices, supplies, and other health care
15 technologies, including diagnostic testing equip-
16 ment.

17 (F) Costs of all incidental services nec-
18 essary for safe patient care and handling.

19 (G) Costs of patient care, education, and
20 prevention programs, including occupational
21 health and safety programs, public health pro-
22 grams, and necessary staff to implement such
23 programs, for the continued education and
24 health and safety of clinicians and other indi-
25 viduals employed by the institutional provider.

1 (2) Administrative costs for the institutional
2 provider.

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

5 (a) IN GENERAL.—In the case of a provider not de-
6 scribed in section 611(a) (including those in group prac-
7 tices who are not receiving payment on a salaried basis
8 described in section 611(a)(3) and providers of home and
9 community-based services), payment for items and serv-
10 ices furnished under this Act for which payment is not
11 otherwise made under section 611 shall be made by the
12 Secretary in amounts determined under the fee schedule
13 established pursuant to subsection (b). Such payment
14 shall be considered to be payment in full for such items
15 and services, and a provider receiving such payment may
16 not charge the individual receiving such item or service
17 in any amount.

18 (b) FEE SCHEDULE.—

19 (1) ESTABLISHMENT.—Not later than 1 year
20 after the date of the enactment of this Act, and in
21 consultation with providers and regional office direc-
22 tors, the Secretary shall establish a national fee
23 schedule for items and services payable under this
24 Act. The Secretary shall evaluate the effectiveness of

1 the fee-for-service structure and update such fee
2 schedule annually.
3 (2) AMOUNTS.—In establishing payment
4 amounts for items and services under the fee sched-
5 ule established under paragraph (1), the Secretary
6 shall take into account—
7 (A) the amounts payable for such items
8 and services under title XVIII of the Social Se-
9 curity Act; and
10 (B) the expertise of providers and value of
11 items and services furnished by such providers.
12 (c) ELECTRONIC BILLING.—The Secretary shall es-
13 tablish a uniform national system for electronic billing for
14 purposes of making payments under this subsection.
15 (d) PHYSICIAN PRACTICE REVIEW BOARD.—Each di-
16 rector of a regional office, in consultation with representa-
17 tives of physicians practicing in that region, shall establish
18 and appoint a physician practice review board to assure
19 quality, cost effectiveness, and fair reimbursements for
20 physician-delivered items and services. The use of mecha-
21 nisms that discriminate against people with disabilities is
22 prohibited for use in any value or cost-effectiveness assess-
23 ments.

1 **SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES**
2 **UNDER THE MEDICARE PHYSICIAN FEE**
3 **SCHEDULE.**

4 (a) STANDARDIZED AND DOCUMENTED REVIEW
5 PROCESS.—Section 1848(c)(2) of the Social Security Act
6 (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the
7 end the following new subparagraph:

8 "(P) STANDARDIZED AND DOCUMENTED
9 REVIEW PROCESS.—

10 "(i) IN GENERAL.—Not later than one
11 year after the date of enactment of this
12 subparagraph, the Secretary shall estab-
13 lish, document, and make publicly avail-
14 able, in consultation with the Office of Pri-
15 mary Health Care, a standardized process
16 for reviewing the relative values of physi-
17 cians' services under this paragraph.

18 "(ii) MINIMUM REQUIREMENTS.—The
19 standardized process shall include, at a
20 minimum, methods and criteria for identi-
21 fying services for review, prioritizing the
22 review of services, reviewing stakeholder
23 recommendations, and identifying addi-
24 tional resources to be considered during
25 the review process.".

1 (b) PLANNED AND DOCUMENTED USE OF FUNDS.—
2 Section 1848(c)(2)(M) of the Social Security Act (42
3 U.S.C. 1395w–4(c)(2)(M)) is amended by adding at the
4 end the following new clause:
5 "(x) PLANNED AND DOCUMENTED
6 USE OF FUNDS.—For each fiscal year (be-
7 ginning with the first fiscal year beginning
8 on or after the date of enactment of this
9 clause), the Secretary shall provide to Con-
10 gress a written plan for using the funds
11 provided under clause (ix) to collect and
12 use information on physicians' services in
13 the determination of relative values under
14 this subparagraph.".
15 (c) INTERNAL TRACKING OF REVIEWS.—
16 (1) IN GENERAL.—Not later than 1 year after
17 the date of enactment of this Act, the Secretary
18 shall submit to Congress a proposed plan for system-
19 atically and internally tracking the Secretary's re-
20 view of the relative values of physicians' services,
21 such as by establishing an internal database, under
22 section 1848(c)(2) of the Social Security Act (42
23 U.S.C. 1395w–4(c)(2)), as amended by this section.
24 (2) MINIMUM REQUIREMENTS.—The proposal
25 shall include, at a minimum, plans and a timeline

1 for achieving the ability to systematically and inter-
2 nally track the following:
3 (A) When, how, and by whom services are
4 identified for review.
5 (B) When services are reviewed or re-
6 viewed or when new services are added.
7 (C) The resources, evidence, data, and rec-
8 ommendations used in reviews.
9 (D) When relative values are adjusted.
10 (E) The rationale for final relative value
11 decisions.
12 (d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of
13 the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is
14 amended—
15 (1) in subparagraph (B)(i), by striking ''5'' and
16 inserting ''4''; and
17 (2) in subparagraph (K)(i)(I), by striking ''peri-
18 odically'' and inserting ''annually''.
19 (e) CONSULTATION WITH MEDICARE PAYMENT AD-
20 VISORY COMMISSION.—
21 (1) IN GENERAL.—Section 1848(c)(2) of the
22 Social Security Act (42 U.S.C. 1395w–4(c)(2)) is
23 amended—
24 (A) in subparagraph (B)(i), by inserting
25 ''in consultation with the Medicare Payment

1 Advisory Commission,'' after ''The Secretary,'';
2 and
3 (B) in subparagraph (K)(i)(I), as amended
4 by subsection (d)(2), by inserting '', in coordi-
5 nation with the Medicare Payment Advisory
6 Commission,'' after ''annually''.
7 (2) CONFORMING AMENDMENTS.—Section 1805
8 of the Social Security Act (42 U.S.C. 1395b–6) is
9 amended—
10 (A) in subsection (b)(1)(A), by inserting
11 the following before the semicolon at the end:
12 ''and including coordinating with the Secretary
13 in accordance with section 1848(c)(2) to sys-
14 tematically review the relative values established
15 for physicians' services, identify potentially
16 misvalued services, and propose adjustments to
17 the relative values for physicians' services''; and
18 (B) in subsection (e)(1), in the second sen-
19 tence, by inserting ''or the Ranking Minority
20 Member'' after ''the Chairman''.
21 (f) PERIODIC AUDIT BY THE COMPTROLLER GEN-
22 ERAL.—Section 1848(c)(2) of the Social Security Act (42
23 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is
24 amended by adding at the end the following new subpara-
25 graph:

1 "(Q) PERIODIC AUDIT BY THE COMP-
2 TROLLER GENERAL.—
3 "(i) IN GENERAL.—The Comptroller
4 General of the United States (in this sub-
5 section referred to as the 'Comptroller
6 General') shall periodically audit the review
7 by the Secretary of relative values estab-
8 lished under this paragraph for physicians'
9 services.
10 "(ii) ACCESS TO INFORMATION.—The
11 Comptroller General shall have unre-
12 stricted access to all deliberations, records,
13 and data related to the activities carried
14 out under this paragraph, in a timely man-
15 ner, upon request.".

16 **SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**
17 **TURES; SPECIAL PROJECTS.**

18 (a) SENSE OF CONGRESS.—It is the sense of Con-
19 gress that tens of millions of people in the United States
20 do not receive healthcare services while billions of dollars
21 that could be spent on providing health care are diverted
22 to profit. There is a moral imperative to correct the mas-
23 sive deficiencies in our current health system and to elimi-
24 nate profit from the provision of health care.

1 (b) PROHIBITIONS.—Payments to providers under
2 this Act may not take into account, include any process
3 for the provision of funding for, or be used by a provider
4 for—
5 (1) marketing of the provider;
6 (2) the profit or net revenue of the provider, or
7 increasing the profit or net revenue of the provider;
8 (3) incentive payments, bonuses, or other com-
9 pensation based on patient utilization of items and
10 services or any financial measure applied with re-
11 spect to the provider (or any group practice, inte-
12 grated health care delivery system, or other provider
13 with which the provider contracts or has a pecuniary
14 interest), including any value-based payment or em-
15 ployment-based compensation;
16 (4) any agreement or arrangement described in
17 section 203(a)(4) of the Labor-Management Report-
18 ing and Disclosure Act of 1959 (29 U.S.C.
19 433(a)(4)); or
20 (5) political or contributions prohibited under
21 section 317 of the Federal Elections Campaign Act
22 of 1971 (52 U.S.C. 30119(a)(1)).
23 (c) PAYMENTS FOR CAPITAL EXPENDITURES.—
24 (1) IN GENERAL.—The Secretary shall pay,
25 from amounts made available for capital expendi-

1 tures pursuant to section 601(a)(2)(B), such sums
2 determined appropriate by the Secretary to providers
3 who have submitted an application to the regional
4 director of the region or regions in which the pro-
5 vider operates or seeks to operate in a time and
6 manner specified by the Secretary for purposes of
7 funding capital expenditures of such providers.

8 (2) PRIORITY.—The Secretary shall prioritize
9 allocation of funding under paragraph (1) to
10 projects that propose to use such funds to improve
11 service in a medically underserved area (as defined
12 in section 330(b)(3) of the Public Health Service
13 Act (42 U.S.C. 254b(b)(3))) or to address health
14 disparities, including racial, ethnic, national origin,
15 primary language use, age, disability, sex (including
16 gender identity and sexual orientation), geography,
17 or socioeconomic health disparities.

18 (3) LIMITATION.—The Secretary shall not
19 grant funding for capital expenditures under this
20 subsection for capital projects that are financed di-
21 rectly or indirectly through the diversion of private
22 or other non-Medicare for All Program funding that
23 results in reductions in care to patients, including
24 reductions in registered nursing staffing patterns

1 and changes in emergency room or primary care
2 services or availability.
3 (4) CAPITAL ASSETS NOT FUNDED BY THE
4 MEDICARE FOR ALL PROGRAM.—Operating expenses
5 and funds shall not be used by an institutional pro-
6 vider receiving payment for capital expenditures
7 under this subsection for a capital asset that was
8 not funded by the Medicare for All program without
9 the approval of the regional director or directors of
10 the region or regions where the capital asset is lo-
11 cated.
12 (d) PROHIBITION AGAINST CO-MINGLING OPER-
13 ATING AND CAPITAL FUNDS.—Providers that receive pay-
14 ment under this title shall be prohibited from using, with
15 respect to funds made available under this Act—
16 (1) funds designated for operating expenditures
17 for capital expenditures or for profit; or
18 (2) funds designated for capital expenditures
19 for operating expenditures.
20 (e) PAYMENTS FOR SPECIAL PROJECTS.—
21 (1) IN GENERAL.—The Secretary shall allocate
22 to each regional director, from amounts made avail-
23 able for special projects pursuant to section
24 601(a)(2)(C), such sums determined appropriate by
25 the Secretary for purposes of funding projects de-

1 scribed in such section, including the construction,
2 renovation, or staffing of health care facilities, in
3 rural, underserved, or health professional or medical
4 shortage areas within such region and to address
5 health disparities, including racial, ethnic, national
6 origin, primary language use, age, disability, sex, in-
7 cluding gender identity and sexual orientation, geog-
8 raphy, or socioeconomic health disparities. Each re-
9 gional director shall, prior to distributing such funds
10 in accordance with paragraph (2), present a budget
11 describing how such funds will be distributed to the
12 Secretary.

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

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

1 **SEC. 615. OFFICE OF HEALTH EQUITY.**

2 Title XVII of the Public Health Service Act (42
3 U.S.C. 300u et seq.) is amended by adding at the end
4 the following:

5 **“SEC. 1712. OFFICE OF HEALTH EQUITY.**

6 ‘‘(a) IN GENERAL.—There is established, in the Of-
7 fice of the Secretary of Health and Human Services, an
8 Office of Health Equity, to be headed by a Director, to
9 ensure coordination and collaboration across the programs
10 and activities of the Department of Health and Human
11 Services with respect to ensuring health equity.

12 ‘‘(b) MONITORING, TRACKING, AND AVAILABILITY OF
13 DATA.—

14 ‘‘(1) IN GENERAL.—In carrying out subsection
15 (a), the Director of the Office of Health Equity shall
16 monitor, track, and make publicly available data
17 on—

18 ‘‘(A) the disproportionate burden of dis-
19 ease and death among people of color,
20 disaggregated by race, major ethnic group,
21 Tribal affiliation, national origin, primary lan-
22 guage use, English proficiency status, immigra-
23 tion status, length of stay in the United States
24 age, disability, sex (including gender identity
25 and sexual orientation), incarceration, home-
26 lessness, geography, and socioeconomic status;

1 “(B) barriers to health, including such
2 barriers relating to income, education, housing,
3 food insecurity (including availability, access,
4 utilization, and stability), employment status,
5 working conditions, and conditions related to
6 the physical environment (including pollutants
7 and population density);
8 “(C) barriers to health care access, includ-
9 ing—
10 “(i) lack of trust and awareness;
11 “(ii) lack of transportation;
12 “(iii) geography;
13 “(iv) hospital and service closures;
14 “(v) lack of health care infrastructure
15 and facilities; and
16 “(vi) lack of health care professional
17 staffing and recruitment;
18 “(D) disparities in quality of care received,
19 including discrimination in health care settings
20 and the use of racially-biased practice guide-
21 lines and algorithms; and
22 “(E) disparities in utilization of care.
23 “(2) ANALYSIS OF CROSS-SECTIONAL INFORMA-
24 TION.—The Director of the Office of Health Equity
25 shall ensure that the data collection and reporting

1 process under paragraph (1) allows for the analysis
2 of cross-sectional information on people's identities.
3 "(c) POLICIES.—In carrying out subsection (a), the
4 Director of the Office of Health Equity shall develop, co-
5 ordinate, and promote policies that enhance health equity,
6 including by—
7 "(1) providing recommendations on—
8 "(A) cultural competence, implicit bias,
9 and ethics training with respect to health care
10 workers;
11 "(B) increasing diversity in the health care
12 workforce; and
13 "(C) ensuring sufficient health care profes-
14 sionals and facilities; and
15 "(2) ensuring adequate public health funding at
16 the local and State levels to address health dispari-
17 ties.
18 "(d) CONSULTATION.—In carrying out subsection
19 (a), the Director of the Office of Health Equity, in coordi-
20 nation with the Director of the Indian Health Service,
21 shall consult with Indian Tribes and with Urban Indian
22 organizations on data collection, reporting, and implemen-
23 tation of policies.

1 "(e) ANNUAL REPORT.—In carrying out subsection
2 (a), the Director of the Office of Health Equity shall de-
3 velop and publish an annual report on—
4 "(1) statistics collected by the Office;
5 "(2) proposed evidence-based solutions to miti-
6 gate health inequities; and
7 "(3) health care professional staffing levels and
8 access to facilities.
9 "(f) CENTRALIZED ELECTRONIC REPOSITORY.—In
10 carrying out subsection (a), the Director of the Office of
11 Health Equity shall—
12 "(1) establish and maintain a centralized elec-
13 tronic repository to incorporate data collected across
14 Federal departments and agencies on race, ethnicity,
15 Tribal affiliation, national origin, primary language
16 use, English proficiency status, immigration status,
17 length of stay in the United States age, disability,
18 sex (including gender identity and sexual orienta-
19 tion), incarceration, homelessness, geography, and
20 socioeconomic status; and
21 "(2) make such data available for public use
22 and analysis.
23 "(g) PRIVACY.—Notwithstanding any other Federal
24 or State law, no Federal or State official or employee or
25 other entity shall disclose, or use, for any law enforcement

1 or immigration purpose, any personally identifiable infor-
2 mation (including with respect to an individual's religious
3 beliefs, practices, or affiliation, national origin, ethnicity,
4 or immigration status) that is collected or maintained pur-
5 suant to this section.''.

6 **SEC. 616. OFFICE OF PRIMARY CARE.**

7 Title XVII of the Public Health Service Act (42
8 U.S.C. 300u et seq.) is amended by adding at the end
9 the following:

10 **''SEC. 1713. OFFICE OF PRIMARY CARE.**

11 ''(a) IN GENERAL.—There is established, in the Of-
12 fice of Health Equity established under section 1712, an
13 Office of Primary Health Care, to be headed by a Direc-
14 tor, to ensure coordination and collaboration across the
15 programs and activities of the Department of Health and
16 Human Services with respect to increasing access to high-
17 quality primary health care, particularly in underserved
18 areas and for underserved populations.

19 ''(b) NATIONAL GOALS.—Not later than 1 year after
20 the date of enactment of this section, the Director of the
21 Office of Primary Health Care shall publish national
22 goals—

23 ''(1) to increase access to high-quality primary
24 health care, particularly in underserved areas and
25 for underserved populations; and

1 “(2) to address health disparities, including
2 with respect to race, ethnicity, national origin
3 (disaggregated by major ethnic group and Tribal af-
4 filiation), primary language use, English proficiency
5 status, immigration status, length of stay in the
6 United States, age, disability, sex (including gender
7 identity and sexual orientation), incarceration, home-
8 lessness, geography, and socioeconomic status.

9 “(c) OTHER RESPONSIBILITIES.—In carrying out
10 subsections (a) and (b), the Director of the Office of Pri-
11 mary Health Care shall—

12 “(1) coordinate, in consultation with the Sec-
13 retary, health professional education policies and
14 goals to achieve the national goals published pursu-
15 ant to subsection (b);

16 “(2) develop and maintain a system to monitor
17 the number and specialties of individuals pursuing
18 careers in, or practicing, primary health care
19 through their health professional education, any
20 postgraduate training, and professional practice;

21 “(3) develop, coordinate, and promote policies
22 that expand the number of primary health care prac-
23 titioners, registered nurses, advance practice clini-
24 cians, and dentists;

1 "(4) recommend appropriate training, technical
2 assistance, and patient protection enhancements for
3 primary care health professionals, including reg-
4 istered nurses, to achieve uniform high quality and
5 patient safety;
6 "(5) provide recommendations on targeted pro-
7 grams and resources for Federally qualified health
8 centers, rural health centers, community health cen-
9 ters, and other community-based organizations;
10 "(6) provide recommendations for broader pa-
11 tient referral to additional resources, not limited to
12 health care, and collaboration with other organiza-
13 tions and sectors that influence health outcomes;
14 and
15 "(7) consult with the Secretary on the alloca-
16 tion of the special projects budget under section
17 601(a)(2)(C) of the Medicare for All Act.
18 "(d) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion shall be construed—
20 "(1) to preempt any provision of State law es-
21 tablishing practice standards or guidelines for health
22 care professionals, including professional licensing or
23 practice laws or regulations; or

1 "(2) to require that any State impose additional
2 educational standards or guidelines for health care
3 professionals.".

4 **SEC. 617. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
5 **PROVED DEVICES AND EQUIPMENT.**

6 The prices to be paid for covered pharmaceuticals,
7 medical supplies, medical technologies, and medically nec-
8 essary equipment covered under this Act shall be nego-
9 tiated annually by the Secretary.

10 (1) IN GENERAL.—Notwithstanding any other
11 provision of law, the Secretary shall, for fiscal years
12 beginning on or after the date of the enactment of
13 this subsection, negotiate with pharmaceutical man-
14 ufacturers the prices (including discounts, rebates,
15 and other price concessions) that may be charged to
16 the Medicare for All Program during a negotiated
17 price period (as specified by the Secretary) for cov-
18 ered drugs for eligible individuals under the Medi-
19 care for All Program. In negotiating such prices
20 under this section, the Secretary shall take into ac-
21 count the following factors:

22 (A) The comparative clinical effectiveness
23 and cost effectiveness, when available from an
24 impartial source, of such drug.

1 (B) The budgetary impact of providing
2 coverage of such drug.
3 (C) The number of similarly effective
4 drugs or alternative treatment regimens for
5 each approved use of such drug.
6 (D) The total revenues from global sales
7 obtained by the manufacturer for such drug
8 and the associated investment in research and
9 development of such drug by the manufacturer.
10 (2) FINALIZATION OF NEGOTIATED PRICE.—
11 The negotiated price of each covered drug for a ne-
12 gotiated price period shall be finalized not later than
13 30 days before the first fiscal year in such nego-
14 tiated price period.
15 (3) COMPETITIVE LICENSING AUTHORITY.—
16 (A) IN GENERAL.—Notwithstanding any
17 exclusivity under clause (iii) or (iv) of section
18 505(j)(5)(F) of the Federal Food, Drug, and
19 Cosmetic Act, clause (iii) or (iv) of section
20 505(c)(3)(E) of such Act, section 351(k)(7)(A)
21 of the Public Health Service Act, or section
22 527(a) of the Federal Food, Drug, and Cos-
23 metic Act, or by an extension of such exclusivity
24 under section 505A of such Act or section 505E
25 of such Act, and any other provision of law that

1 provides for market exclusivity (or extension of
2 market exclusivity) with respect to a drug, in
3 the case that the Secretary is unable to success
4 fully negotiate an appropriate price for a cov-
5 ered drug for a negotiated price period, the Sec-
6 retary shall authorize the use of any patent,
7 clinical trial data, or other exclusivity granted
8 by the Federal Government with respect to such
9 drug as the Secretary determines appropriate
10 for purposes of manufacturing such drug for
11 sale under Medicare for All Program. Any enti-
12 ty making use of a competitive license to use
13 patent, clinical trial data, or other exclusivity
14 under this section shall provide to the manufac-
15 turer holding such exclusivity reasonable com-
16 pensation, as determined by the Secretary
17 based on the following factors:

18 (i) The risk-adjusted value of any
19 Federal Government subsidies and invest-
20 ments in research and development used to
21 support the development of such drug.

22 (ii) The risk-adjusted value of any in-
23 vestment made by such manufacturer in
24 the research and development of such
25 drug.

1 (iii) The impact of the price, including
2 license compensation payments, on meeting
3 the medical need of all patients at a rea-
4 sonable cost.
5 (iv) The relationship between the
6 price of such drug, including compensation
7 payments, and the health benefits of such
8 drug.
9 (v) Other relevant factors determined
10 appropriate by the Secretary to provide
11 reasonable compensation.
12 (B) REASONABLE COMPENSATION.—The
13 manufacturer described in subparagraph (A)
14 may seek recovery against the United States in
15 the United States Court of Federal Claims.
16 (C) INTERIM PERIOD.—Until 1 year after
17 a drug described in subparagraph (A) is ap-
18 proved under section 505(j) of the Federal
19 Food, Drug, and Cosmetic Act or section
20 351(k) of the Public Health Service Act and is
21 provided under license issued by the Secretary
22 under such subparagraph, the Medicare for All
23 Program shall not pay more for such drug than
24 the average of the prices available, during the
25 most recent 12-month period for which data is

1 available prior to the beginning of such nego-
2 tiated price period, from the manufacturer to
3 any wholesaler, retailer, provider, health main-
4 tenance organization, nonprofit entity, or gov-
5 ernmental entity in the ten OECD (Organiza-
6 tion for Economic Cooperation and Develop-
7 ment) countries that have the largest gross do-
8 mestic product with a per capita income that is
9 not less than half the per capita income of the
10 United States.

11 (D) AUTHORIZATION FOR SECRETARY TO
12 PROCURE DRUGS DIRECTLY.—The Secretary
13 may procure a drug manufactured pursuant to
14 a competitive license under subparagraph (A)
15 for purposes of this Act.

16 (4) FDA REVIEW OF LICENSED DRUG APPLICA-
17 TIONS.—The Secretary shall prioritize review of ap-
18 plications under section 505(j) of the Federal Food,
19 Drug, and Cosmetic Act for drugs licensed under
20 paragraph (3)(A).

21 (5) PROHIBITION OF ANTICOMPETITIVE BEHAV-
22 IOR.—No drug manufacturer may engage in anti-
23 competitive behavior with another manufacturer that
24 may interfere with the issuance and implementation

1 of a competitive license or run contrary to public
2 policy.
3 (6) REQUIRED REPORTING.—The Secretary
4 may require pharmaceutical manufacturers to dis-
5 close to the Secretary such information that the Sec-
6 retary determines necessary for purposes of carrying
7 out this subsection.

8 TITLE VII—UNIVERSAL
9 MEDICARE TRUST FUND

10 SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

11 (a) IN GENERAL.—There is hereby created on the
12 books of the Treasury of the United States a trust fund
13 to be known as the Universal Medicare Trust Fund (in
14 this section referred to as the ''Trust Fund''). The Trust
15 Fund shall consist of such gifts and bequests as may be
16 made and such amounts as may be deposited in, or appro-
17 priated to, such Trust Fund as provided in this Act.
18 (b) APPROPRIATIONS INTO TRUST FUND.—
19 (1) TAXES.—There are appropriated to the
20 Trust Fund for each fiscal year beginning with the
21 fiscal year which includes the date on which benefits
22 first become available as described in section 106,
23 out of any moneys in the Treasury not otherwise ap-
24 propriated, amounts equivalent to 100 percent of the
25 net increase in revenues to the Treasury which is at-

1 tributable to the amendments made by sections 801
2 and 902. The amounts appropriated by the pre-
3 ceding sentence shall be transferred from time to
4 time (but not less frequently than monthly) from the
5 general fund in the Treasury to the Trust Fund,
6 such amounts to be determined on the basis of esti-
7 mates by the Secretary of the Treasury of the taxes
8 paid to or deposited into the Treasury, and proper
9 adjustments shall be made in amounts subsequently
10 transferred to the extent prior estimates were in ex-
11 cess of or were less than the amounts that should
12 have been so transferred.
13 (2) CURRENT PROGRAM RECEIPTS.—
14 (A) INITIAL YEAR.—Notwithstanding any
15 other provision of law, there is appropriated to
16 the Trust Fund for the fiscal year containing
17 January 1 of the first year following the date
18 of the enactment of this Act, an amount equal
19 to the aggregate amount appropriated for the
20 preceding fiscal year for the following (in-
21 creased by the consumer price index for all
22 urban consumers for the fiscal year involved):
23 (i) The Medicare program under title
24 XVIII of the Social Security Act (other

1 than amounts attributable to any pre-
2 miums under such title).
3 (ii) The Medicaid program under
4 State plans approved under title XIX of
5 such Act.
6 (iii) The Federal Employees Health
7 Benefits program, under chapter 89 of title
8 5, United States Code.
9 (iv) The purchased care component of
10 the TRICARE program, under chapter 55
11 of title 10, United States Code (other than
12 amounts appropriated for the purchased
13 care component of the TRICARE Overseas
14 Program).
15 (v) The maternal and child health
16 program (under title V of the Social Secu-
17 rity Act), vocational rehabilitation pro-
18 grams, programs for drug abuse and men-
19 tal health services under the Public Health
20 Service Act, programs providing general
21 hospital or medical assistance, and any
22 other Federal program identified by the
23 Secretary, in consultation with the Sec-
24 retary of the Treasury, to the extent the
25 programs provide for payment for health

1 services the payment of which may be
2 made under this Act.
3 (B) SUBSEQUENT YEARS.—Notwithstand-
4 ing any other provision of law, there is appro-
5 priated to the trust fund for the fiscal year con-
6 taining January 1 of the second year following
7 the date of the enactment of this Act, and for
8 each fiscal year thereafter, an amount equal to
9 the amount appropriated to the Trust Fund for
10 the previous year, adjusted for reductions in
11 costs resulting from the implementation of this
12 Act, changes in the consumer price index for all
13 urban consumers for the fiscal year involved,
14 and other factors determined appropriate by the
15 Secretary.
16 (3) RESTRICTIONS SHALL NOT APPLY.—Any
17 other provision of law in effect on the date of enact-
18 ment of this Act restricting the use of Federal funds
19 for any reproductive health service shall not apply to
20 monies in the Trust Fund.
21 (c) INCORPORATION OF PROVISIONS.—The provisions
22 of subsections (b) through (i) of section 1817 of the Social
23 Security Act (42 U.S.C. 1395i) shall apply to the Trust
24 Fund under this section in the same manner as such pro-
25 visions applied to the Federal Hospital Insurance Trust

1 Fund under such section 1817, except that, for purposes
2 of applying such subsections to this section, the ''Board
3 of Trustees of the Trust Fund'' shall mean the ''Sec-
4 retary''.

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

14 TITLE VIII—CONFORMING 15 AMENDMENTS TO THE EM- 16 PLOYEE RETIREMENT IN- 17 COME SECURITY ACT OF 1974

18 SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA- 19 TIVE OF BENEFITS UNDER THE MEDICARE 20 FOR ALL PROGRAM; COORDINATION IN CASE 21 OF WORKERS' COMPENSATION.

22 (a) IN GENERAL.—Part 5 of subtitle B of title I of
23 the Employee Retirement Income Security Act of 1974
24 (29 U.S.C. 1131 et seq.) is amended by adding at the end
25 the following new section:

1 **"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**
2 **CATIVE OF UNIVERSAL MEDICARE PROGRAM**
3 **BENEFITS; COORDINATION IN CASE OF**
4 **WORKERS' COMPENSATION.**

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

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

13 "(c) DEFINITIONS.—In this subsection—

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

20 "(2) the term 'workers compensation medical
21 benefits' means, with respect to an enrollee who is
22 an employee subject to the workers compensation
23 laws of a State, the comprehensive medical benefits
24 for work-related injuries and illnesses provided for
25 under such laws with respect to such an employee;
26 and

1 "(3) the term 'workers compensation services'
2 means items and services included in workers com-
3 pensation medical benefits and includes items and
4 services (including rehabilitation services and long-
5 term care services) commonly used for treatment of
6 work-related injuries and illnesses.".

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

13 (c) CLERICAL AMENDMENT.—The table of contents
14 in section 1 of such Act is amended by inserting after the
15 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.".

16 **SEC. 802. APPLICATION OF CONTINUATION COVERAGE RE-**
17 **QUIREMENTS UNDER ERISA AND CERTAIN**
18 **OTHER REQUIREMENTS RELATING TO**
19 **GROUP HEALTH PLANS.**

20 (a) IN GENERAL.—Part 6 of subtitle B of title I of
21 the Employee Retirement Income Security Act of 1974
22 (29 U.S.C. 1161 et seq.) shall apply only with respect to
23 any employee health benefit plan that does not duplicate

payments for any items or services for which payment may be made under the this Act.

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

''(c) Subsection (a) shall apply to any group health plan that does not duplicate payments for any items or services for which payment may be made under the Medicare for All Act.''.

SEC. 803. EFFECTIVE DATE OF TITLE.

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

(1) IN GENERAL.—Notwithstanding any other provision of law and with respect to an individual eligible to enroll under this Act, subject to paragraphs (2) and (3)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any

1 item or service furnished beginning on the date
2 that is 2 years after the date of the enactment
3 of this Act;

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

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

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

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

1 ation of benefits under such title or plan until the
2 end of the period of stay.
3 (3) SCHOOL PROGRAMS.—All school related
4 health programs, centers, initiatives, services, or
5 other activities or work provided under title XIX or
6 title XXI of the Social Security Act as of January
7 1, 2019, shall be continued and covered by the Medi-
8 care for All Program.
9 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
10 GRAM.—No benefits shall be made available under chapter
11 89 of title 5, United States Code, with respect to items
12 and services furnished to any individual eligible to enroll
13 under this Act.
14 (c) TRICARE PROGRAM.—
15 (1) DIRECT CARE COMPONENT.—Nothing in
16 this Act shall affect the eligibility of beneficiaries
17 under chapter 55 of title 10, United States Code,
18 who are entitled to receive care furnished at facilities
19 of the uniformed services under the TRICARE pro-
20 gram for such care.
21 (2) PURCHASED CARE COMPONENT.—
22 (A) IN GENERAL.—Except as provided in
23 subparagraph (B), no benefits shall be made
24 available under the purchased care component
25 of the TRICARE program for items or services

1 furnished to any individual eligible to enroll
2 under this Act.
3 (B) TRICARE OVERSEAS.—During any
4 period in which an individual is eligible for ben-
5 efits under the TRICARE Overseas Program
6 and is located in a TRICARE overseas region,
7 the individual may receive benefits for items or
8 services furnished to the individual under the
9 purchased care component of such program
10 during such period.
11 (d) TREATMENT OF BENEFITS FOR VETERANS AND
12 NATIVE AMERICANS.—
13 (1) IN GENERAL.—Nothing in this Act shall af-
14 fect the eligibility of veterans for the medical bene-
15 fits and services provided under title 38, United
16 States Code, or of Indians for the medical benefits
17 and services provided by or through the Indian
18 Health Service.
19 (2) REEVALUATION.—No reevaluation of the
20 Indian Health Service shall be undertaken without
21 consultation with tribal leaders and stakeholders.
22 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**
23 **EXCHANGES.**
24 Effective on the date that is 2 years after the date
25 of the enactment of this Act, the Federal and State Ex-

1 changes established pursuant to title I of the Patient Pro-
2 tection and Affordable Care Act (Public Law 111–148)
3 shall terminate, and any other provision of law that relies
4 upon participation in or enrollment through such an Ex-
5 change, including such provisions of the Internal Revenue
6 Code of 1986, shall cease to have force or effect.

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

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

15 (1) the Merit-based Incentive Payment System
16 established pursuant to subsection (q) of section
17 1848 of the Social Security Act (42 U.S.C. 1395w–
18 4(q));

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

23 (3) the incentives for adoption and meaningful
24 use of certified EHR technology established pursu-

1 ant to subsection (o) of section 1848 of the Social
2 Security Act (42 U.S.C. 1395w–4(o));
3 (4) alternative payment models established
4 under section 1833(z) of the Social Security Act (42
5 U.S.C. 1395(z)); and
6 (5) the following programs as established pur-
7 suant to the following sections of the Patient Protec-
8 tion and Affordable Care Act:
9 (A) Section 2701 (adult health quality
10 measures).
11 (B) Section 2702 (payment adjustments
12 for health care acquired conditions).
13 (C) Section 2706 (Pediatric Accountable
14 Care Organization Demonstration Projects for
15 the purposes of receiving incentive payments).
16 (D) Section 3002(b) (42 U.S.C. 1395w–
17 4(a)(8)) (incentive payments for quality report-
18 ing).
19 (E) Section 3001(a) (42 U.S.C.
20 1395ww(o)) (Hospital Value-Based Purchas-
21 ing).
22 (F) Section 3006 (value-based purchasing
23 program for skilled nursing facilities and home
24 health agencies).

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

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

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

(J) Section 3023 (42 U.S.C. 1395cc–4) (National Pilot Program on Payment Bundling).

(K) Section 3024 (42 U.S.C. 1395cc–5) (Independence at home demonstration program).

(L) Section 3025 (42 U.S.C. 1395ww(q)) (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.

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

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

1 "(A) The individual meets the eligibility re-
2 quirements established by the Secretary under
3 title I of the Medicare for All Act.
4 "(B) The individual has attained the appli-
5 cable year of age, or is currently enrolled in
6 Medicare at the time of the transition to Medi-
7 care for All.
8 "(4) APPLICABLE YEAR OF AGE DEFINED.—
9 For purposes of this section, the term 'applicable
10 year of age' means one year after the date of enact-
11 ment of the Medicare for All Act, the age of 55 or
12 older, the age 18 or younger.
13 "(b) ENROLLMENT; COVERAGE.—The Secretary shall
14 establish enrollment periods and coverage under this sec-
15 tion consistent with the principles for establishment of en-
16 rollment periods and coverage for individuals under other
17 provisions of this title. The Secretary shall establish such
18 periods so that coverage under this section shall first begin
19 on January 1 of the year on which an individual first be-
20 comes eligible to enroll under this section.
21 "(c) SATISFACTION OF INDIVIDUAL MANDATE.—For
22 purposes of applying section 5000A of the Internal Rev-
23 enue Code of 1986, the coverage provided under this sec-
24 tion constitutes minimum essential coverage under sub-
25 section (f)(1)(A)(i) of such section 5000A.

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

6 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**
7 **TION BUY-IN.**

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

18 (b) ADMINISTERING THE MEDICARE TRANSITION
19 BUY-IN.—

20 (1) ADMINISTRATOR.—The Administrator shall
21 administer the Medicare Transition buy-in in accord-
22 ance with this section.

23 (2) APPLICATION OF ACA REQUIREMENTS.—
24 Consistent with this section, the Medicare Transition
25 buy-in shall comply with requirements under title I

1 of the Patient Protection and Affordable Care Act
2 (and the amendments made by that title) and title
3 XXVII of the Public Health Service Act (42 U.S.C.
4 300gg et seq.) that are applicable to qualified health
5 plans offered through the Exchanges, subject to the
6 limitation under subsection (e)(2).

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

15 (4) ELIGIBILITY TO PURCHASE.—Any United
16 States resident may enroll in the Medicare Transi-
17 tion buy-in.

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

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

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

1 (d) PROVIDERS AND REIMBURSEMENT RATES.—
2 (1) IN GENERAL.—With respect to the reim-
3 bursement provided to health care providers for cov-
4 ered benefits, as described in section 201, provided
5 under the Medicare Transition buy-in, the Adminis-
6 trator shall reimburse such providers at rates deter-
7 mined for equivalent items and services under the
8 Medicare for All fee-for-service schedule established
9 in section 612(b) of this Act.
10 (2) PRESCRIPTION DRUGS.—Any payment rate
11 under this subsection for a prescription drug shall be
12 at the prices negotiated under section 616 of this
13 Act.
14 (3) PARTICIPATING PROVIDERS.—
15 (A) IN GENERAL.—A health care provider
16 that is a participating provider of services or
17 supplier under the Medicare program under
18 title XVIII of the Social Security Act (42
19 U.S.C. 1395 et seq.) or under a State Medicaid
20 plan under title XIX of such Act (42 U.S.C.
21 1396 et seq.) on the date of enactment of this
22 Act shall be a participating provider in the
23 Medicare Transition buy-in.
24 (B) ADDITIONAL PROVIDERS.—The Ad-
25 ministrator shall establish a process to allow

1 health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition buy-in. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) PREMIUMS.—

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

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

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

(2) LIMITATION.—Variation in premium rates of the Medicare Transition buy-in by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii)

1 of the Public Health Service Act (42 U.S.C.
2 300gg(a)(1)(A)) is not permitted.
3 (f) TERMINATION.—This section shall cease to have
4 force or effect on the effective date described in section
5 106(a).
6 (g) TAX CREDITS AND COST-SHARING SUBSIDIES.—
7 (1) PREMIUM ASSISTANCE TAX CREDITS.—
8 (A) CREDITS ALLOWED TO MEDICARE
9 TRANSITION BUY-IN ENROLLEES IN NON-EX-
10 PANSION STATES.—Paragraph (1) of section
11 36B(c) of the Internal Revenue Code of 1986
12 is amended by redesignating subparagraphs (C)
13 and (D) as subparagraphs (D) and (E), respec-
14 tively, and by inserting after subparagraph (B)
15 the following new subparagraph:
16 "(C) SPECIAL RULES FOR MEDICARE
17 TRANSITION BUY-IN ENROLLEES.—
18 "(i) IN GENERAL.—In the case of a
19 taxpayer who is covered, or whose spouse
20 or dependent (as defined in section 152) is
21 covered, by the Medicare Transition buy-in
22 established under section 1002(a) of the
23 Medicare for All Act for all months in the
24 taxable year, subparagraph (A) shall be

1 applied without regard to 'but does not ex-
2 ceed 400 percent'.
3 "(ii) ENROLLEES IN MEDICAID NON-
4 EXPANSION STATES.—In the case of a tax-
5 payer residing in a State which (as of the
6 date of the enactment of the Medicare for
7 All Act) does not provide for eligibility
8 under clause (i)(VIII) or (ii)(XX) of sec-
9 tion 1902(a)(10)(A) of the Social Security
10 Act for medical assistance under title XIX
11 of such Act (or a waiver of the State plan
12 approved under section 1115) who is cov-
13 ered, or whose spouse or dependent (as de-
14 fined in section 152) is covered, by the
15 Medicare Transition buy-in established
16 under section 1002(a) of the Medicare for
17 All Act for all months in the taxable year,
18 subparagraphs (A) and (B) shall be ap-
19 plied by substituting '0 percent' for '100
20 percent' each place it appears.".
21 (B) PREMIUM ASSISTANCE AMOUNTS FOR
22 TAXPAYERS ENROLLED IN MEDICARE TRANSI-
23 TION BUY-IN.—
24 (i) IN GENERAL.—Subparagraph (A)
25 of section 36B(b)(3) of such Code is

1 amended—(I) by redesignating clause (ii)
2 as clause (iii), (II) by striking ''clause (ii)''
3 in clause (i) and inserting ''clauses (ii) and
4 (iii)'', and (III) by inserting after clause (i)
5 the following new clause:

6 ''(ii) SPECIAL RULES FOR TAXPAYERS
7 ENROLLED IN MEDICARE TRANSITION BUY-
8 IN.—In the case of a taxpayer who is cov-
9 ered, or whose spouse or dependent (as de-
10 fined in section 152) is covered, by the
11 Medicare Transition buy-in established
12 under section 1002(a) of the Medicare for
13 All Act for all months in the taxable year,
14 the applicable percentage for any taxable
15 year shall be determined in the same man-
16 ner as under clause (i), except that the fol-
17 lowing table shall apply in lieu of the table
18 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.''.

19 (ii) CONFORMING AMENDMENT.—Sub-
20 clause (I) of clause (iii) of section
21 36B(b)(3) of such Code, as redesignated

1 by subparagraph (A)(i), is amended by in-
2 serting ", and determined after the appli-
3 cation of clause (ii)" after "after applica-
4 tion of this clause".
5 (2) COST-SHARING SUBSIDIES.—Subsection (b)
6 of section 1402 of the Patient Protection and Af-
7 fordable Care Act (42 U.S.C. 18071(b)) is amend-
8 ed—
9 (A) by inserting ", or in the Medicare
10 Transition buy-in established under section
11 1002(a) of the Medicare for All Act," after
12 "coverage" in paragraph (1);
13 (B) by redesignating paragraphs (1) (as so
14 amended) and (2) as subparagraphs (A) and
15 (B), respectively, and by moving such subpara-
16 graphs 2 ems to the right;
17 (C) by striking "INSURED.—In this sec-
18 tion" and inserting "INSURED.—
19 "(1) IN GENERAL.—In this section";
20 (D) by striking the flush language; and
21 (E) by adding at the end the following new
22 paragraph:
23 "(2) SPECIAL RULES.—
24 "(A) INDIVIDUALS LAWFULLY PRESENT.—
25 In the case of an individual described in section

1 36B(c)(1)(B) of the Internal Revenue Code of
2 1986, the individual shall be treated as having
3 household income equal to 100 percent of the
4 poverty line for a family of the size involved for
5 purposes of applying this section.

6 "(B) MEDICARE TRANSITION BUY-IN EN-
7 ROLLEES IN MEDICAID NON-EXPANSION
8 STATES.—In the case of an individual residing
9 in a State which (as of the date of the enact-
10 ment of the Medicare for All Act) does not pro-
11 vide for eligibility under clause (i)(VIII) or
12 (ii)(XX) of section 1902(a)(10)(A) of the Social
13 Security Act for medical assistance under title
14 XIX of such Act (or a waiver of the State plan
15 approved under section 1115) who enrolls in
16 such Medicare Transition buy-in, the preceding
17 sentence, paragraph (1)(B), and paragraphs
18 (1)(A)(i) and (2)(A) of subsection (c) shall each
19 be applied by substituting '0 percent' for '100
20 percent' each place it appears.".

21 (h) CONFORMING AMENDMENTS.—

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

1 (A) in the paragraph heading, by inserting
2 "THE MEDICARE TRANSITION BUY-IN," before
3 "AND"; and
4 (B) by inserting "The Medicare Transition
5 buy-in," before "and a multi-State plan".
6 (2) LEVEL PLAYING FIELD.—Section 1324(a)
7 of the Patient Protection and Affordable Care Act
8 (42 U.S.C. 18044(a)) is amended by inserting "the
9 Medicare Transition buy-in," before "or a multi-
10 State qualified health plan".

11 Subtitle B—Transitional Medicare 12 Reforms

13 SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD 14 FOR MEDICARE COVERAGE FOR INDIVID- 15 UALS WITH DISABILITIES.

16 (a) IN GENERAL.—Section 226(b) of the Social Secu-
17 rity Act (42 U.S.C. 426(b)) is amended—
18 (1) in paragraph (2)(A), by striking ", and has
19 for 24 calendar months been entitled to,";
20 (2) in paragraph (2)(B), by striking ", and has
21 been for not less than 24 months,";
22 (3) in paragraph (2)(C)(ii), by striking ", in-
23 cluding the requirement that he has been entitled to
24 the specified benefits for 24 months,";

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

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

14 (b) CONFORMING AMENDMENTS.—

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

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

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

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

1 (3) MEDICARE COVERAGE.—Section 1837(g)(1)
2 of the Social Security Act (42 U.S.C. 1395p(g)(1))
3 is amended by striking ''25th month of'' and insert-
4 ing ''month following the first month of''.
5 (4) RAILROAD RETIREMENT SYSTEM.—Section
6 7(d)(2)(ii) of the Railroad Retirement Act of 1974
7 (45 U.S.C. 231f(d)(2)(ii)) is amended—
8 (A) by striking ''has been entitled to an
9 annuity'' and inserting ''is entitled to an annu-
10 ity'';
11 (B) by striking '', for not less than 24
12 months''; and
13 (C) by striking ''could have been entitled
14 for 24 calendar months, and''.
15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to insurance benefits under title
17 XVIII of the Social Security Act with respect to items and
18 services furnished in months beginning after December 1
19 following the date of enactment of this Act, and before
20 the date that is 2 years after the date of the enactment
21 of such Act.
22 **SEC. 1012. ENSURING CONTINUITY OF CARE.**
23 (a) IN GENERAL.—The Secretary shall ensure that
24 all persons enrolled or who seeks to enroll in a health plan
25 during the transition period of the Medicare for All Pro-

gram are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

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

(c) CONTINUITY OF COVERAGE AND CARE FOR PERSONS WITH COMPLEX MEDICAL NEEDS.—

(1) The Secretary shall ensure that persons with disabilities, complex medical needs, or chronic conditions are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

(2) During the transition period of the Medicare for All Act group health plans and health insurance issuers offering group or individual health insurance coverage shall not—

(A) end coverage for an enrollee who has a disability, complex medical need, or chronic

1 condition during the transition period described
2 in the Act until all ages are eligible to enroll in
3 the Medicare for All Program; or
4 (B) impose any exclusion with respect to
5 such plan or coverage on the basis of a person's
6 disability, complex medical need, or chronic con-
7 dition during the transition period described
8 under this Act until all ages are eligible to en-
9 roll in the Medicare for All Program.
10 (d) PUBLIC CONSULTATION DURING TRANSITION.—
11 The Secretary shall consult with communities and advo-
12 cacy organizations of persons living with disabilities as
13 well as other patient advocacy organizations to ensure that
14 the transition buy-in takes into account the continuity of
15 care for persons with disabilities, complex medical needs,
16 or chronic conditions.

17 # TITLE XI—MISCELLANEOUS

18 **SEC. 1101. DEFINITIONS.**

19 In this Act—
20 (1) the term "global budget" means the pay-
21 ment negotiated between an institutional provider
22 and as described in section 611(b);
23 (2) the term "group practice" has the meaning
24 given such term in section 1877(h)(4) of the Social
25 Security Act (42 U.S.C. 1395nn(h)(4));

1 (3) the term ''individual provider'' means a sup-
2 plier (as defined in section 1861(d) of such Act (42
3 U.S.C. 1395x(d)));
4 (4) the term ''institutional provider'' means—
5 (A) providers of services described in sec-
6 tion 1861(u) of such Act (42 U.S.C. 1395x(u));
7 (B) hospitals as defined in section 1861(e)
8 of the Social Security Act (42 U.S.C.
9 1395x(e)), and any outpatient settings or clinics
10 operating within a hospital license or any set-
11 ting or clinic that provides outpatient hospital
12 services;
13 (C) psychiatric hospitals (as defined in sec-
14 tion 1861(e) of the Social Security Act (42
15 U.S.C. 1395x(f)));
16 (D) rehabilitation hospitals (as defined by
17 the Secretary of Health and Human Services
18 under section 1886(d)(1)(B)(ii) of the Social
19 Security Act (42 U.S.C. 1395ww(d)(1)(B)(ii)));
20 (E) long-term care hospitals as defined in
21 section 1861 of the Social Security Act (42
22 U.S.C. 1395x(ccc)); and
23 (F) independent dialysis facilities and inde-
24 pendent end-stage renal disease facilities as de-
25 scribed in 42 CFR 413.174(b);

1 (5) the term ''medically necessary or appro-
2 priate'' means the health care items and services or
3 supplies that are needed or appropriate to prevent,
4 diagnose, or treat an illness, injury, condition, dis-
5 ease, or its symptoms for an individual and are de-
6 termined to be necessary or appropriate for such in-
7 dividual by the physician or other health care profes-
8 sional treating such individual, after such profes-
9 sional performs an assessment of such individual's
10 condition, in a manner that meets—
11 (A) the scope of practice, licensing, and
12 other law of the State in which the individual
13 receiving such items and services is located; and
14 (B) appropriate standards established by
15 the Secretary for purposes of carrying out this
16 Act;
17 (6) the term ''provider'' means an institutional
18 provider or a supplier (as defined in section 1861(d)
19 of such Act (42 U.S.C. 1395x(d)) if the reference to
20 ''this title'' were a reference to the Medicare for All
21 Program);
22 (7) the term ''Secretary'' means the Secretary
23 of Health and Human Services;

1 (8) the term "State" means a State, the Dis-
2 trict of Columbia, or a territory of the United
3 States;
4 (9) the term "TRICARE Overseas Program"
5 means the element of the TRICARE program ad-
6 ministered by International SOS (or such successor
7 administrator) under which care and health benefits
8 are furnished to TRICARE beneficiaries located in
9 a TRICARE overseas region;
10 (10) the term "TRICARE program" has the
11 meaning given such term in section 1072 of title 10,
12 United States Code;
13 (11) the term "uniformed services" has the
14 meaning given such term in section 101 of title 10,
15 United States Code; and
16 (12) the term "United States" shall include the
17 States, the District of Columbia, and the territories
18 of the United States.

19 **SEC. 1102. RULES OF CONSTRUCTION.**

20 (a) In General.—A State or local government may
21 set additional standards or apply other State or local laws
22 with respect to eligibility, benefits, and minimum provider
23 standards, only if such State or local standards—
24 (1) provide equal or greater eligibility than is
25 available under this Act;

1 (2) provide equal or greater in-person access to
2 benefits under this Act;
3 (3) do not reduce access to benefits under this
4 Act;
5 (4) allow for the effective exercise of the profes-
6 sional judgment of physicians or other health care
7 professionals; and
8 (5) are otherwise consistent with this Act.
9 (b) RELATION TO STATE LICENSING LAW.—Nothing
10 in this Act shall be construed to preempt State licensing,
11 practice, or educational laws or regulations with respect
12 to health care professionals and health care providers, for
13 such professionals and providers who practice in that
14 State.
15 (c) APPLICATION TO STATE AND FEDERAL LAW ON
16 WORKPLACE RIGHTS.—Nothing in this Act shall be con-
17 strued to diminish or alter the rights, privileges, remedies,
18 or obligations of any employee or employer under any Fed-
19 eral or State law or regulation or under any collective bar-
20 gaining agreement.
21 (d) RESTRICTIONS ON PROVIDERS.—With respect to
22 any individuals or entities certified to provide items and
23 services covered under section 201(a)(7), a State may not
24 prohibit an individual or entity from participating in the

1 program under this Act for reasons other than the ability
2 of the individual or entity to provide such services.

3 **SEC. 1103. NO USE OF RESOURCES FOR LAW ENFORCE-**
4 **MENT OF CERTAIN REGISTRATION REQUIRE-**
5 **MENTS.**

6 Notwithstanding any provision of Federal or State
7 law, no Federal or State law enforcement official or em-
8 ployee shall use any funds, facilities, property, equipment,
9 or personnel made available pursuant to this Act (or any
10 amendment made thereby) to investigate, enforce, or as-
11 sist in the investigation or enforcement of any criminal,
12 civil, or administrative violation or warrant for a violation
13 of any requirement that individuals register with the Fed-
14 eral Government based on religion, national origin, eth-
15 nicity, immigration status, or other protected category.

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