Medicare for All Act of 2019 Section-by-Section

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

Universal coverage.

- Establishes the Medicare for All Program entitling all United States residents to benefits for health care services.
- Authorizes the HHS Secretary to determine criteria of residency.

Freedom of choice.

- Allows any individual entitled to benefits to obtain services from any provider qualified to participate under the Act.

Non-discrimination.

- Prohibits discrimination by providers or entities administering the Program on the basis of race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy or related medical conditions (including termination of pregnancy).
- Requires the HHS Secretary to establish a process for adjudicating claims of discrimination.
- Establishes a private right of action to enforce the prohibition on discrimination.

Enrollment.

- Requires the Secretary to provide a mechanism for automatic enrollment at birth, time of immigration into the US, or acquisition of qualified resident status and to issue Medicare for All Program cards.

Effective date of benefits.

- Establishes a two-year transition period for the Medicare for All Program and makes benefits available to all eligible individuals two years after the date of enactment.
- Provides that individuals under 19 and 55 or older are eligible for benefits one year after the date of enactment.

Prohibition against duplicating coverage.

- Prohibits the sale of health insurance coverage that duplicates the benefits available under the Program.
- Prohibits employers from providing benefits that duplicate the benefits under the Medicare for All Program.
- Allows the sale of insurance and employer-sponsored benefits that provide supplemental coverage.

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

Comprehensive benefits.

- Authorizes payment to providers for Program benefits where such items or services are medically necessary or appropriate for the individual as determined by their treating physician or other licensed health care provider with the appropriate scope of practice.
- Lists covered benefits including:
    - Hospital services, including inpatient and outpatient hospital care, 24-hour-a-day emergency services and inpatient prescription drugs.
    - Ambulatory patient services.
    - Primary and preventive services, including chronic disease management.
    - Prescription drugs, medical devices and biological products, including outpatient prescription drugs, medical devices, and biological products.
    - Mental health and substance abuse treatment services, including inpatient care.
    - Laboratory and diagnostic services.
    - Comprehensive reproductive, maternity, and newborn care.
    - Pediatrics.
    - Dental, audiology, and vision services.
    - Rehabilitative and habilitative services and devices.
    - Dietary and nutritional therapies approved by the Secretary.
    - Emergency services and transportation.
    - Early and periodic screening, diagnostic, and treatment services.
    - Transportation to receive health care services for persons with disabilities or low-income individuals.
    - Long-term care services and supports.
- Authorizes the Secretary to evaluate benefits and give recommendations to Congress for improvements and adjustments to the benefits package.
- Requires the Secretary to consult with experts to identify complementary and integrative medicine practices that are appropriate to include in the benefits package.
- Permits States to provide additional benefits and to provide benefits to individuals who may not be eligible for the Medicare for All Program.

No cost-sharing.

- Prohibits cost-sharing and balance billing for benefits provided through the Medicare for All Program.

Exclusions and limitations.

- Provides that Program benefits are not available to the individual unless they are medically necessary or appropriate.
- Authorizes the Secretary to include coverage of experimental items and services and requires the Secretary to establish an appeals process.
- Allows health care professionals, who by their scope of practice and licensure can exercise independent professional judgment, to override national practice guidelines if consistent with the professional's assessment of the individual, in the individual's best interest, and consistent with the individual's wishes.

Coverage of long-term care services.

- Entitles Program enrollees to long-term services and supports where illness, injury, or age limit their ability to perform one or more activities of daily living or similar need of assistance to perform instrumental activities of daily living.
- Long-term services and supports include: nursing and medical services, long-term rehabilitative and habilitative services, and services to support activities of daily living and instrumental activities of daily living whether provided in an institution, home, or community-based setting.
- Requires that such services be provided in the most integrative and least restrictive setting and that they maximize the recipient's autonomy as well as their civic, social, and economic participation.
- Requires that the Program presume that recipients of all ages and disabilities will receive long-term services and supports through home and community-based services unless the individual chooses otherwise.
- Requires that the Secretary develop regulations in consultation with an advisory commission that includes those who use long-term supports and services, their representatives and family caregivers; providers of such supports and services; and disability rights, academic, and labor organizations

TITLE III—PROVIDER PARTICIPATION

Provider participation and standards; whistleblower protections.

- Describes provisions required in the participation agreement between providers and the Program.
- Requires disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations.
- Establishes a duty of provider ethics for participating physicians and other health care providers and prohibits hospitals and other institutional providers from limiting the ability of such professionals to advocate for medically necessary and appropriate care.
- Prohibits bonuses, incentive payments, or compensation based on utilization of services or the financial results of any health care provider and requires providers to disclose financial interests or relationships with other providers to the Secretary.

- Establishes the process for terminating a participation agreement.
- Establishes protections for participating providers and whistleblower protections for individuals that report potential violations of the Act.
- Prohibits providers or their board members from serving on the board of or receiving compensation, stock, or other financial investments in any other entity that furnishes items and services (including pharmaceuticals and medical devices) to the provider.

Qualifications for providers.

- Establishes that providers are qualified to participate in the Program if they have the requisite license from the state in which they practice and meet minimum provider standards including adequate facilities, safe staffing, and patient access.

Use of private contracts.

- Prohibits participating providers from entering into private contracts for covered services with individuals eligible for Program benefits and establishes penalties for violating this prohibition.
- Permits participating providers to enter into private contracts with individuals ineligible for benefits under the Program and with eligible individuals for noncovered services, and establishes conditions for these contracts.
- Establishes conditions under which nonparticipating providers may enter into a private contract with individuals eligible for benefits under the Program.
- Entering into a private contract with an eligible individual for covered services bars the provider from participating in the Program for one calendar year.

TITLE IV—ADMINISTRATION

Administration.

- Outlines the duties of the Secretary to include developing policies, procedures, and guidelines to ensure the timely and accessible provision of benefits under the Act.
- Lists the types of information that providers must report including and data the provider is required to report to any State or local agency and annual financial data.
- Requires the Secretary to report on the Program to Congress and regular audits by the Comptroller General.

Consultation.

- Requires the Secretary to consult with other federal agencies, Indian tribes, labor organizations representing health care workers, health care experts, etc. in the administration of the Act.

Regional administration.

- Requires the Secretary to establish regional offices and appoint regional directors, incorporating the existing offices of the Centers for Medicare & Medicaid Services (CMS) where possible. Also requires appointment of deputy directors to represent American Indian and Alaska Native tribes in each region.

- Details the duties of regional directors including performing health care needs assessments, recommending changes in provider reimbursement or payment, and establishing quality assurance mechanisms in their respective regions.

Beneficiary ombudsman.

- Establishes a beneficiary ombudsman to receive complaints and grievances and to provide assistance to individuals entitled to benefits under the Act.

Conduct of related health programs.

- Requires the Secretary to direct activities of other health-related programs to complement this Act and contribute to the health of the people.

Subtitle B—Control Over Fraud and Abuse

Application of federal sanctions to all fraud and abuse under the Medicare for All Program.

- Incorporates the fraud and abuse sanctions as well as limitations on referrals that already exist under Medicare or Medicaid.

TITLE V—QUALITY ASSESSMENT

Quality standards.

- Requires that all Program standards and quality measures be implemented and evaluated by the CMS Center for Clinical Standards and Quality in coordination with the Agency for Healthcare Research and Quality and other HHS offices.
- Establishes the Center's duties to include reviewing and evaluating practice guidelines, quality standards, and performance measures; creating methodology to monitor and evaluate patterns of practice for appropriate utilization; developing competency criteria to qualify independent organizations to conduct quality reviews at the regional level; and reporting findings to the Secretary.

Addressing health care disparities.

- Requires CMS's Center for Clinical Standards and Quality to evaluate data collection methods to ensure accurate reporting of health care disparities on the basis of race, ethnicity, gender, geography, and socioeconomic status and report the results to Congress and the Secretary.
- Requires the Secretary to implement effective approaches for data collection.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

National health budget.

- Requires the Secretary to establish a national health budget covering the following: operating expenditures, capital expenditures, special projects for rural or medically

underserved areas, quality assessments, health professional education, administrative costs, and prevention and public health activities.

- Requires the Secretary to allocate funds to each regional office to carry out the Program in such region.
- Allocates at least 1 percent of the budget for the first five years to worker assistance programs for those displaced or affected by the implementation of the Act. Assistance programs shall include wage replacement, retirement benefits, job training, and education benefits.
- Requires the Secretary to establish a reserve fund to cover the costs of treating epidemics, natural disasters, and other health emergencies, and for market-shift adjustments necessary due to patient volume.

Subtitle B—Payments to Providers

Payments to institutional providers based on global budgets.

- Establishes that institutional providers—including hospitals, skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—be paid a lump sum global operating budget on a quarterly basis to provide covered items and services.
- Requires regional directors to review institutional providers' performance on a quarterly basis and determine whether adjustments to the budget are needed.
- Requires regional directors to negotiate the global budget with institutional providers each fiscal year and establishes factors addressed in the negotiations including:
    - The historical volume of services in the previous 3-year period and provider capacity.
    - Actual expenditures based on the most recent Medicare cost report of the provider and compared to other providers within the region and to the normative payment rates established under a national comparative rate system.
    - Projected changes in volume and type of items and services to be furnished.
    - Employee wages, including staffing increases necessary for safe registered nurse-to-patient staffing ratios and optimal staffing of physicians and other health care professionals.
    - Education and prevention programs.
    - And other relevant factors and adjustments.
- Requires regional directors to review institutional providers' performance on a quarterly basis and determine whether adjustments to the budget are needed, including for additional funding needed for unanticipated care for individuals with complex medical needs or market-shift adjustments.
- Establishes that the operating expenses in the global budget must not include capital expenditures, and that funding from an institution's global budget cannot be used for capital expenditures.
- Requires that a system be established to enable cost comparisons among institutional providers.

Payment to individual providers through fee-for-service.

- Requires that individual providers, including individuals in medical group practices, be paid on a fee-for-service basis.
- Requires the Secretary to establish a national fee schedule that takes into account the prevailing rates under Medicare, provider expertise, and the value of the items and services furnished.
- Establishes a physician consultation review board to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.
- Requires a periodic audit by the Comptroller General.

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

- Amends the Social Security Act to include a standardized documentation and review process of the relative values of physician services to determine appropriate fee payments.

Payment prohibitions; capital expenditures; special projects.

- Prohibits providers from using payments from the Medicare for All Program for marketing expenses, increasing profit or revenue, incentive payments or bonuses based on patient utilization, compensation for labor relations consultants, or for political activity.
- Requires providers seeking capital expenditure funds to present an application to fund such capital project for review by regional directors and prohibits comingling of operations funding with capital expenditures.
- Requires regional directors seeking funding for special projects for construction, renovation, or staffing of health care facilities in rural, underserved, or shortage areas to present a budget for review to the Secretary.

Office of primary health care.

- Establishes an Office of Primary Health Care, which develops and coordinates national goals related to education of health care professionals and expanding the number of primary care practitioners.

Payments for prescription drugs and approved devices and equipment.

- Requires the Secretary to negotiate prices for pharmaceuticals, medical supplies, and medically necessary equipment based on factors including comparative clinical and cost effectiveness, budget impact of providing coverage, number of similarly effective drugs, and total revenues from global sales obtained by the manufacturer for such drug.
- Requires the Secretary, in the case of an unsuccessful negotiation at an appropriate price and price period, to authorize the use of any patent, clinical trial data, or other exclusivity with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under the Medicare for All Program.
- Prohibits anticompetitive behavior by manufacturers that may interfere with issuance and implementation of a competitive license.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Universal Medicare Trust Fund.

- Establishes a Universal Medicare Trust Fund in the Treasury.
- Requires that, during the first fiscal year benefits are available under the Medicare for All Program, amounts equal to those appropriated the preceding year to Medicare, Medicaid, and other federal health programs be deposited in the Fund. Thereafter, funds equal to the previous year (adjusted for cost savings resulting from implementation of the Medicare for All Program and for changes in the consumer price index) shall be deposited.
- Prohibits restrictions on the Fund related to reproductive health services.

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

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

- Adds new sections to ERISA including a prohibition on employee benefits plans that duplicate payment for items or services that are benefits under the Medicare for All Program and a requirement that workers' compensation carriers reimburse the Medicare for All Program for costs of services furnished.

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

- Amends ERISA's continuation of coverage requirements to apply only to plans that do not duplicate payment for items and services that are benefits under the Medicare for All Program.

Effective date of title.

- The effective date of Title 8 is the date on which benefits are available under the Medicare for All Program.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

Relationship to existing Federal health programs.

- Maintains existing medical benefits or services under the Department of Veteran Affairs and the Indian Health Service.
- Requires the Secretary to provide for continuation of benefits for people who are receiving inpatient hospital services and extended care services under Medicare, Medicaid, or the Children's Health Insurance Program during the transition to the Medicare for All Program.
- Continues school related health programs under the Medicare for All Program.

Sunset of provisions related to the State Exchanges.

- Sunsets the Federal and State Exchanges two years after the enactment of the Medicare for All Act of 2019.

Sunset of provisions related to pay for performance programs.

- Sunsets federal programs related to pay for performance payments and value-based purchasing for medical benefits or services.

TITLE X—TRANSITION

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

Medicare for All transition over two years.

- Establishes a transition period of two years for the Medicare for All Program and amends the Social Security Act to entitle individuals age 55 or older, age 18 or younger, or who are currently enrolled in Medicare to enroll and obtain benefits under the Medicare for All Program.
- Establishes that enrollment in the Medicare for All Program satisfies the individual mandate for health care coverage requirements under the Internal Revenue Code.
- Requires the Secretary to consult with beneficiary representatives, health care providers, employers, and insurance companies during the transition.

Establishment of the Medicare buy-in plan.

- Establishes a Medicare Transition buy-in plan during the two-year transition period that will be offered through the Federal and State Exchanges. The benefits will be the same benefits available under the Medicare for All Program.
- Allows those who are ineligible to enroll in Medicare for All during the two year transition, to enroll in the Medicare Transition buy-in plan.
- Authorizes the CMS Administrator to set premiums for the Medicare Transition buy-in plan.
- Requires that tax credits, premium assistance, and cost-sharing subsidies currently available under the Patient Protection and Affordable Care Act apply to Medicare Transition buy-in enrollees and makes them available to Medicare Transition buy-in enrollees who live in a Medicaid non-expansion state.

Subtitle B—Transitional Medicare Reforms

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

- Strikes the 24-month waiting period for Medicare coverage for individuals with disabilities.

Ensuring continuity of care.

- Requires that the Secretary ensure continuity of care during the Medicare for All transition period for individuals enrolled in health insurance plans.
- Prohibits health insurers from ending coverage of enrollees during the Medicare for All transition period except for reasons expressly agreed upon under the terms of a plan.
- Protects people with disabilities, complex medical needs, or chronic conditions from disruptions in their care from health insurers ending coverage or imposing plan or coverage exclusions during the transition period.

TITLE XI—MISCELLANEOUS

Definitions.

Rules of Construction.

- Permits States and local government to expand benefits or eligibility and to set additional state provider standards if there is no reduction of benefits or access and does not limit the professional judgment of providers.
- Prohibits States from barring providers of reproductive services from participating in the Program for reasons other than the provider's ability to provide such services.
- Establishes that this shall not be construed to preempt state licensing, practice, or education laws, unless expressly preempted under the Act.
- Establishes that no other workplace rights under Federal or State law or collective bargaining agreement is diminished or altered by the Act