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(Original Signature of Member)

117TH CONGRESS  
1ST SESSION

# H. R.

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

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## IN THE HOUSE OF REPRESENTATIVES

Ms. JAYAPAL introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

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# A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Medicare for All Act of 2021”.

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. Division 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.

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

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

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

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

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

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

1 ing health care items and services provided under the pro-  
2 gram established under this Act.

3 **SEC. 103. FREEDOM OF CHOICE.**

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

7 **SEC. 104. NON-DISCRIMINATION.**

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

24 (b) CLAIMS OF DISCRIMINATION.—

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

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

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

16          (c) CONTINUED APPLICATION OF LAWS.—Nothing in  
17          this title (or an amendment made by this title) shall be  
18          construed to invalidate or otherwise limit any of the rights,  
19          remedies, procedures, or legal standards available to indi-  
20          viduals aggrieved under section 1557 of the Patient Pro-  
21          tection and Affordable Care Act (42 U.S.C. 18116), title  
22          VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et  
23          seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.  
24          2000e et seq.), title IX of the Education Amendments of  
25          1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-

1 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-  
2 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing  
3 in this title (or an amendment to this title) shall be con-  
4 strued to supersede State laws that provide additional pro-  
5 tections against discrimination on any basis described in  
6 subsection (a).

7 **SEC. 105. ENROLLMENT.**

8 (a) IN GENERAL.—The Secretary shall provide a  
9 mechanism for the enrollment of individuals eligible for  
10 benefits under this Act. The mechanism shall—

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

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

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

22 (b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—  
23 In conjunction with an individual's enrollment for benefits  
24 under this Act, the Secretary shall provide for the issuance  
25 of a Universal Medicare card that shall be used for pur-

1 poses of identification and processing of claims for bene-  
2 fits under this program. The card shall not include an in-  
3 dividual's Social Security number.

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

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

9 (b) COVERAGE FOR CERTAIN INDIVIDUALS.—

10 (1) IN GENERAL.—For any eligible individual  
11 who—

12 (A) has not yet attained the age of 19 as  
13 of the date that is 1 year after the date of the  
14 enactment of this Act; or

15 (B) has attained the age of 55 as of the  
16 date that is 1 year after the date of the enact-  
17 ment of this Act,

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

20 (2) OPTION TO CONTINUE IN OTHER COVERAGE

21 DURING TRANSITION PERIOD.—Any person who is  
22 eligible to receive benefits as described in paragraph

23 (1) may opt to maintain any coverage described in  
24 section 901, private health insurance coverage, or  
25 coverage offered pursuant to subtitle A of title X



1 (including the amendments made by such subtitle)  
2 until the date described in subsection (a).

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

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

6 (1) a private health insurer to sell health insur-  
7 ance coverage that duplicates the benefits provided  
8 under this Act; or

9 (2) an employer to provide benefits for an em-  
10 ployee, former employee, or the dependents of an  
11 employee or former employee that duplicate the ben-  
12 efits provided under this Act.

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

19 **TITLE II—COMPREHENSIVE BEN-**  
20 **EFITS, INCLUDING PREVEN-**  
21 **TIVE BENEFITS AND BENE-**  
22 **FITS FOR LONG-TERM CARE**

23 **SEC. 201. COMPREHENSIVE BENEFITS.**

24 (a) IN GENERAL.—Subject to the other provisions of  
25 this title and titles IV through IX, individuals enrolled for

1 benefits under this Act are entitled to have payment made  
2 by the Secretary to an eligible provider for the following  
3 items and services if medically necessary or appropriate  
4 for the maintenance of health or for the diagnosis, treat-  
5 ment, or rehabilitation of a health condition:

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

9 (2) Ambulatory patient services.

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

12 (4) Prescription drugs and medical devices, in-  
13 cluding outpatient prescription drugs, medical de-  
14 vices, and biological products.

15 (5) Mental health and substance use treatment  
16 services, including inpatient care.

17 (6) Laboratory and diagnostic services.

18 (7) Comprehensive reproductive, maternity, and  
19 newborn care.

20 (8) Oral health, audiology, and vision services.

21 (9) Rehabilitative and habilitative services and  
22 devices.

23 (10) Emergency services and transportation.

24 (11) Early and periodic screening, diagnostic,  
25 and treatment services, as described in sections

1 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and  
2 1905(r) of the Social Security Act (42 U.S.C.  
3 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B);  
4 1396d(r)).

5 (12) Necessary transportation to receive health  
6 care services for persons with disabilities, older indi-  
7 viduals with functional limitations, or low-income in-  
8 dividuals (as determined by the Secretary).

9 (13) Long-term care services and support (as  
10 described in section 204).

11 (14) Hospice care.

12 (15) Services provided by a licensed marriage  
13 and family therapist or a licensed mental health  
14 counselor.

15 (b) REVISION.—The Secretary shall, at least annu-  
16 ally, and on a regular basis, evaluate whether the benefits  
17 package should be improved to promote the health of bene-  
18 ficiaries, account for changes in medical practice or new  
19 information from medical research, or respond to other  
20 relevant developments in health science, and shall make  
21 recommendations to Congress regarding any such im-  
22 provements. Such recommendations may not include a rec-  
23 ommendation to eliminate any benefit.

24 (c) HEARINGS.—

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

7           (2) EXERCISE OF RULEMAKING AUTHORITY.—  
8           Paragraph (1) is enacted—

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

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

21           (d) COMPLEMENTARY AND INTEGRATIVE MEDI-  
22           CINE.—

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

1 (A) identifying specific complementary and  
2 integrative medicine practices that are appro-  
3 priate to include in the benefits package; and

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

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

10 (A) the Director of the National Center for  
11 Complementary and Integrative Health;

12 (B) the Commissioner of Food and Drugs;

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

19 (D) nationally recognized providers of com-  
20plementary and integrative medicine; and

21 (E) such other officials, entities, and indi-  
22viduals with expertise on complementary and  
23integrative medicine as the Secretary deter-  
24mines appropriate.

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

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

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

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

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

19 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

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

24 (b) TREATMENT OF EXPERIMENTAL ITEMS AND  
25 SERVICES AND DRUGS.—

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

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

14          (c) APPLICATION OF PRACTICE GUIDELINES.—

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

1 (A) exercised appropriate professional  
2 judgment in accordance with the laws and re-  
3 quirements of the State in which such item or  
4 service is furnished in deviating from the guide-  
5 line;

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

8 (C) acted in a manner consistent with the  
9 individual's wishes.

10 (2) OVERRIDE OF STANDARDS.—

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



1 port technology, and computerized order entry  
2 programs.

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

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

11 (ii) in the best interests of the indi-  
12 vidual; and

13 (iii) consistent with the individual’s  
14 wishes.

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

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

1 tion, whether physical or mental, of health, injury, or age  
2 that—

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

5 (2) requires a similar need of assistance in per-  
6 forming instrumental activities of daily living.

7 (b) ELIGIBILITY.—An individual shall be eligible for  
8 services and supports described in this section if such indi-  
9 vidual has one or more medically determinable conditions  
10 described in subsection (a).

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

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

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

22 (3) provide coverage that meets the physical,  
23 mental, and social needs of recipients while allowing  
24 recipients their maximum possible autonomy and

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

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

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

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

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

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

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

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

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

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

10 (3) groups that represent the diversity of the  
11 population of people living with disabilities, including  
12 racial, ethnic, national origin, primary language use,  
13 age, sex, including gender identity and sexual ori-  
14 entation, geographical, and socioeconomic diversity;

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

18 (5) disability rights organizations; and

19 (6) relevant academic institutions and research-  
20 ers.

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

25 (f) DEFINITIONS.—In this section:

1           (1) The term “long-term services and supports”  
2           means long-term care, treatment, maintenance, or  
3           services needed to support the activities of daily liv-  
4           ing and instrumental activities of daily living, includ-  
5           ing home and community-based services and any ad-  
6           ditional services and supports identified by the Sec-  
7           retary to support people with disabilities to live,  
8           work, and participate in their communities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (iii) by a provider.

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

12 (C) PROVIDER PROTECTIONS.—

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

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

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

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

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

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

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

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

4           (c) WHISTLEBLOWER PROTECTIONS.—

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

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

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

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

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

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

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

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

15 (3) APPLICATION.—

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

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

10       (4) DEFINITIONS.—In this subsection:

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

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



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

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

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

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

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

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

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

25 (c) MINIMUM PROVIDER STANDARDS.—

1           (1) IN GENERAL.—The Secretary shall estab-  
2           lish, evaluate, and update national minimum stand-  
3           ards to ensure the quality of items and services pro-  
4           vided under this Act and to monitor efforts by  
5           States to ensure the quality of such items and serv-  
6           ices. A State may establish additional minimum  
7           standards which providers shall meet with respect to  
8           items and services provided in such State.

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

21                   (A) adequacy and quality of facilities;

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

1 (C) training and competence of personnel  
2 (including requirements related to the number  
3 of or type of required continuing education  
4 hours);

5 (D) comprehensiveness of service;

6 (E) continuity of service;

7 (F) patient waiting time, access to serv-  
8 ices, and preferences; and

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

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

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

1       entity's or provider's ability to provide such items  
2       and services.

3       (d) **FEDERAL PROVIDERS.**—Any provider qualified to  
4       provide health care items and services through the Depart-  
5       ment of Veterans Affairs, the Indian Health Service, or  
6       the uniformed services (with respect to the direct care  
7       component of the TRICARE Program) is a qualifying pro-  
8       vider under this section with respect to any individual who  
9       qualifies for such items and services under applicable Fed-  
10      eral law.

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

12      (a) **IN GENERAL.**—This section shall apply beginning  
13      2 years after the date of the enactment of this Act.

14      (b) **PARTICIPATING PROVIDERS.**—

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

22              (2) **PRIVATE CONTRACTS FOR NONCOVERED**  
23              **ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.**—  
24              An institutional or individual provider with an agree-  
25              ment in effect under section 301 may bill or enter

1 into a private contract with an individual eligible for  
2 benefits under the Act for any item or service that  
3 is not a benefit under this Act only if—

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

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

9 (C) the provider receives—

10 (i) no reimbursement under this Act  
11 directly or indirectly for such item or serv-  
12 ice, and

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

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

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

1 (B) not be entered into at a time when the  
2 individual is facing an emergency health care  
3 situation; and

4 (C) clearly indicate to the individual receiv-  
5 ing such items and services that by signing  
6 such a contract the individual—

7 (i) agrees not to submit a claim (or to  
8 request that the provider submit a claim)  
9 under this Act for such items or services;

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

15 (iii) acknowledges that no limits under  
16 this Act apply to amounts that may be  
17 charged for such items or services; and

18 (iv) acknowledges that the provider is  
19 providing services outside the scope of the  
20 program under this Act.

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

1 (A) identify the provider who is to furnish  
2 such noncovered item or service, and be signed  
3 by such provider;

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

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

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

18 (A) any contract described in paragraph  
19 (2) shall be null and void;

20 (B) no payment shall be made under this  
21 title for any item or service furnished by the  
22 provider during the 2-year period beginning on  
23 the date the affidavit was signed; and

1 (C) any payment received under this title  
2 for any item or service furnished during such  
3 period shall be remitted.

4 (6) PRIVATE CONTRACTS FOR INELIGIBLE INDI-  
5 VIDUALS.—An institutional or individual provider  
6 with an agreement in effect under section 301 may  
7 bill or enter into a private contract with any indi-  
8 vidual ineligible for benefits under the Act for any  
9 item or service.

10 (c) NONPARTICIPATING PROVIDERS.—

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

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

23 (A) be in writing and signed by the indi-  
24 vidual (or authorized representative of the indi-  
25 vidual) receiving the item or service before the



1 item or service is furnished pursuant to the  
2 contract;

3 (B) not be entered into at a time when the  
4 individual is facing an emergency health care  
5 situation; and

6 (C) clearly indicate to the individual receiv-  
7 ing such items and services that by signing  
8 such a contract the individual—

9 (i) acknowledges that the individual  
10 has the right to have such items or services  
11 provided by other providers for whom pay-  
12 ment would be made under this Act;

13 (ii) agrees not to submit a claim (or  
14 to request that the provider submit a  
15 claim) under this Act for such items or  
16 services even if such items or services are  
17 otherwise covered by this Act;

18 (iii) agrees to be responsible for pay-  
19 ment of such items or services and under-  
20 stands that no reimbursement will be pro-  
21 vided under this Act for such items or  
22 services;

23 (iv) acknowledges that no limits under  
24 this Act apply to amounts that may be  
25 charged for such items or services; and

1 (v) acknowledges that the provider is  
2 providing services outside the scope of the  
3 program under this Act.

4 (3) AFFIDAVIT.—A provider who enters into a  
5 contract described in paragraph (1) shall have in ef-  
6 fect during the period any item or service is to be  
7 provided pursuant to the contract an affidavit that  
8 shall—

9 (A) identify the provider who is to furnish  
10 such covered item or service, and be signed by  
11 such provider;

12 (B) state that the provider will not submit  
13 any claim under this Act for any covered item  
14 or service provided to any individual enrolled  
15 under this Act during the 2-year period begin-  
16 ning on the date the affidavit is signed; and

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

20 (4) ENFORCEMENT.—If a provider signing an  
21 affidavit described in paragraph (3) knowingly and  
22 willfully submits a claim under this title for any item  
23 or service provided or receives any reimbursement or  
24 amount for any such item or service provided pursu-

1 ant to a private contract described in paragraph (1)  
2 with respect to such affidavit—

3 (A) any contract described in paragraph  
4 (1) shall be null and void; and

5 (B) no payment shall be made under this  
6 title for any item or service furnished by the  
7 provider during the 2-year period beginning on  
8 the date the affidavit was signed.

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

## 15 **TITLE IV—ADMINISTRATION**

### 16 **Subtitle A—General**

#### 17 **Administration Provisions**

##### 18 **SEC. 401. ADMINISTRATION.**

19 (a) GENERAL DUTIES OF THE SECRETARY.—

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

23 (A) eligibility for benefits;

24 (B) enrollment;

25 (C) benefits provided;

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

3 (E) levels of funding;

4 (F) methods for determining amounts of  
5 payments to providers of covered items and  
6 services, consistent with subtitle B;

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

10 (H) planning for capital expenditures and  
11 service delivery;

12 (I) planning for health professional edu-  
13 cation funding;

14 (J) encouraging States to develop regional  
15 planning mechanisms; and

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

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

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

1 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-  
2 PORT; STUDIES.—

3 (1) UNIFORM REPORTING STANDARDS.—

4 (A) IN GENERAL.—The Secretary shall es-  
5 tablish uniform State reporting requirements  
6 and national standards to ensure an adequate  
7 national database containing information per-  
8 taining to health services practitioners, ap-  
9 proved providers, the costs of facilities and  
10 practitioners providing items and services, the  
11 quality of such items and services, the outcomes  
12 of such items and services, and the equity of  
13 health among population groups. Such database  
14 shall include, to the maximum extent feasible  
15 without compromising patient privacy, health  
16 outcome measures used under this Act, and to  
17 the maximum extent feasible without excessively  
18 burdening providers, a description of the stand-  
19 ards and qualifications, levels of finding, and  
20 methods described in subparagraphs (D)  
21 through (F) of subsection (a)(1).

22 (B) REQUIRED DATA DISCLOSURES.—In  
23 establishing reporting requirements and stand-  
24 ards under subparagraph (A), the Secretary  
25 shall require a provider with an agreement in

1 effect under section 301 to disclose to the Sec-  
2 retary, in a time and manner specified by the  
3 Secretary, the following (as applicable to the  
4 type of provider):

5 (i) Any data the provider is required  
6 to report or does report to any State or  
7 local agency, or, as of January 1, 2019, to  
8 the Secretary or any entity that is part of  
9 the Department of Health and Human  
10 Services, except data that are required  
11 under the programs terminated in section  
12 903.

13 (ii) Annual financial data that in-  
14 cludes information on employees (including  
15 the number of employees, hours worked,  
16 and wage information) by job title and by  
17 each patient care unit or department with-  
18 in each facility (including outpatient units  
19 or departments); the number of registered  
20 nurses per staffed bed by each such unit or  
21 department; information on the dollar  
22 value and annual spending (including pur-  
23 chases, upgrades, and maintenance) for  
24 health information technology; and risk-ad-  
25 justed and raw patient outcome data (in-

1 cluding data on medical, surgical, obstet-  
2 ric, and other procedures).

3 (C) REPORTS.—The Secretary shall regu-  
4 larly analyze information reported to the Sec-  
5 retary and shall define rules and procedures to  
6 allow researchers, scholars, health care pro-  
7 viders, and others to access and analyze data  
8 for purposes consistent with quality and out-  
9 comes research, without compromising patient  
10 privacy.

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

14 (A) The status of implementation of the  
15 Act.

16 (B) Enrollment under this Act.

17 (C) Benefits under this Act.

18 (D) Expenditures and financing under this  
19 Act.

20 (E) Cost-containment measures and  
21 achievements under this Act.

22 (F) Quality assurance.

23 (G) Health care utilization patterns, in-  
24 cluding any changes attributable to the pro-  
25 gram.

1 (H) Changes in the per-capita costs of  
2 health care.

3 (I) Differences in the health status of the  
4 populations of the different States, including by  
5 racial, ethnic, national origin, primary language  
6 use, age, disability, sex, including gender iden-  
7 tity and sexual orientation, geographical, and  
8 income characteristics;

9 (J) Progress on quality and outcome meas-  
10 ures, and long-range plans and goals for  
11 achievements in such areas.

12 (K) Plans for improving service to medi-  
13 cally underserved populations.

14 (L) Transition problems as a result of im-  
15 plementation of this Act.

16 (M) Opportunities for improvements under  
17 this Act.

18 (3) STATISTICAL ANALYSES AND OTHER STUD-  
19 IES.—The Secretary may, either directly or by con-  
20 tract—

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

24 (B) develop and test methods of delivery of  
25 items and services as the Secretary may con-



1           sider necessary or promising for the evaluation,  
2           or for the improvement, of the operation of this  
3           Act; and

4                   (C) develop methodological standards for  
5           policymaking.

6           (c) AUDITS.—

7                   (1) IN GENERAL.—The Comptroller General of  
8           the United States shall conduct an audit of the De-  
9           partment of Health and Human Services every fifth  
10          fiscal year following the effective date of this Act to  
11          determine the effectiveness of the program in car-  
12          rying out the duties under subsection (a).

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

17   **SEC. 402. CONSULTATION.**

18          The Secretary shall consult with Federal agencies,  
19          Indian tribes and urban Indian health organizations, and  
20          private entities, such as labor organizations representing  
21          health care workers, professional societies, national asso-  
22          ciations, nationally recognized associations of health care  
23          experts, medical schools and academic health centers, con-  
24          sumer groups, and business organizations in the formula-  
25          tion of guidelines, regulations, policy initiatives, and infor-

1 mation gathering to ensure the broadest and most in-  
2 formed input in the administration of this Act. Nothing  
3 in this Act shall prevent the Secretary from adopting  
4 guidelines, consistent with the provisions of section 203(c),  
5 developed by such a private entity if, in the Secretary's  
6 judgment, such guidelines are generally accepted as rea-  
7 sonable and prudent and consistent with this Act.

8 **SEC. 403. REGIONAL ADMINISTRATION.**

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

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

19 (1) one regional director appointed by the Sec-  
20 retary; and

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

1           (3) one deputy director appointed by the re-  
2           gional director to oversee long-term services and  
3           supports.

4           (c) REGIONAL OFFICE DUTIES.—Each regional di-  
5           rector shall—

6           (1) provide an annual health care needs assess-  
7           ment with respect to the region under the director’s  
8           jurisdiction to the Secretary after a thorough exam-  
9           ination of health needs and in consultation with pub-  
10          lic health officials, clinicians, patients, and patient  
11          advocates;

12          (2) recommend any changes in provider reim-  
13          bursement or payment for delivery of health services  
14          determined appropriate by the regional director, sub-  
15          ject to the provisions of title VI; and

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

21 **SEC. 404. BENEFICIARY OMBUDSMAN.**

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

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

2 (1) receive complaints, grievances, and requests  
3 for information submitted by individuals enrolled  
4 under this Act or eligible to enroll under this Act  
5 with respect to any aspect of the Medicare for All  
6 Program;

7 (2) provide assistance with respect to com-  
8 plaints, grievances, and requests referred to in para-  
9 graph (1), including assistance in collecting relevant  
10 information for such individuals, to seek an appeal  
11 of a decision or determination made by a regional of-  
12 fice or the Secretary; and

13 (3) submit annual reports to Congress and the  
14 Secretary that describe the activities of the Ombuds-  
15 man and that include such recommendations for im-  
16 provement in the administration of this Act as the  
17 Ombudsman determines appropriate. The Ombuds-  
18 man shall not serve as an advocate for any increases  
19 in payments or new coverage of services, but may  
20 identify issues and problems in payment or coverage  
21 policies.

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

23 In performing functions with respect to health per-  
24 sonnel education and training, health research, environ-  
25 mental health, disability insurance, vocational rehabilita-

1 tion, the regulation of food and drugs, and all other mat-  
2 ters pertaining to health, the Secretary shall direct the ac-  
3 tivities of the Department of Health and Human Services  
4 toward contributions to the health of the people com-  
5 plementary to this Act.

6 **Subtitle B—Control Over Fraud**  
7 **and Abuse**

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

11 The following sections of the Social Security Act shall  
12 apply to this Act in the same manner as they apply to  
13 title XVIII or State plans under title XIX of the Social  
14 Security Act:

15 (1) Section 1128 (relating to exclusion of indi-  
16 viduals and entities).

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

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

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

21 (5) Section 1126 (relating to disclosure of cer-  
22 tain owners).

23 (6) Section 1877 (relating to physician refer-  
24 rals).

# 1 **TITLE V—QUALITY ASSESSMENT**

## 2 **SEC. 501. QUALITY STANDARDS.**

3 (a) IN GENERAL.—All standards and quality meas-  
4 ures under this Act shall be implemented and evaluated  
5 by the Center for Clinical Standards and Quality of the  
6 Centers for Medicare & Medicaid Services (referred to in  
7 this title as the “Center”) or such other agency deter-  
8 mined appropriate by the Secretary, in coordination with  
9 the Agency for Healthcare Research and Quality and other  
10 offices of the Department of Health and Human Services.

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

13 (1) Review and evaluate each practice guideline  
14 developed under part B of title IX of the Public  
15 Health Service Act. In so reviewing and evaluating,  
16 the Center shall determine whether the guideline  
17 should be recognized as a national practice guideline  
18 in accordance with and subject to the provisions of  
19 section 203(c).

20 (2) Review and evaluate each standard of qual-  
21 ity, performance measure, and medical review cri-  
22 terion developed under part B of title IX of the Pub-  
23 lic Health Service Act (42 U.S.C. 299 et seq.). In  
24 so reviewing and evaluating, the Center shall deter-  
25 mine whether the standard, measure, or criterion is

1 appropriate for use in assessing or reviewing the  
2 quality of items and services provided by health care  
3 institutions or health care professionals. The use of  
4 mechanisms that discriminate against people with  
5 disabilities is prohibited for use in any value or cost-  
6 effectiveness assessments. The Center shall consider  
7 the evidentiary basis for the standard, and the valid-  
8 ity, reliability, and feasibility of measuring the  
9 standard.

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

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

24 (5) Submission of a report to the Secretary an-  
25 nually specifically on findings from outcomes re-

1 search and development of practice guidelines that  
2 may affect the Secretary's determination of coverage  
3 of services under section 401(a)(1)(G).

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

5 (a) EVALUATING DATA COLLECTION AP-  
6 PROACHES.—The Center shall evaluate approaches for the  
7 collection of data under this Act, to be performed in con-  
8 junction with existing quality reporting requirements and  
9 programs under this Act, that allow for the ongoing, accu-  
10 rate, and timely collection of data on disparities in health  
11 care services and performance on the basis of race, eth-  
12 nicity, national origin, primary language use, age, dis-  
13 ability, sex (including gender identity and sexual orienta-  
14 tion), geography, or socioeconomic status. In conducting  
15 such evaluation, the Center shall consider the following ob-  
16 jectives:

17 (1) Protecting patient privacy.

18 (2) Minimizing the administrative burdens of  
19 data collection and reporting on providers under this  
20 Act.

21 (3) Improving data on race, ethnicity, national  
22 origin, primary language use, age, disability, sex (in-  
23 cluding gender identity and sexual orientation), ge-  
24 ography, and socioeconomic status.

25 (b) REPORTS TO CONGRESS.—



1           (1) REPORT ON EVALUATION.—Not later than  
2           18 months after the date on which benefits first be-  
3           come available as described in section 106(a), the  
4           Center shall submit to Congress and the Secretary  
5           a report on the evaluation conducted under sub-  
6           section (a). Such report shall, taking into consider-  
7           ation the results of such evaluation—

8                   (A) identify approaches (including defining  
9                   methodologies) for identifying and collecting  
10                  and evaluating data on health care disparities  
11                  on the basis of race, ethnicity, national origin,  
12                  primary language use, age, disability, sex (in-  
13                  cluding gender identity and sexual orientation),  
14                  geography, or socioeconomic status under the  
15                  Medicare for All Program; and

16                   (B) include recommendations on the most  
17                  effective strategies and approaches to reporting  
18                  quality measures, as appropriate, on the basis  
19                  of race, ethnicity, national origin, primary lan-  
20                  guage use, age, disability, sex (including gender  
21                  identity and sexual orientation), geography, or  
22                  socioeconomic status.

23           (2) REPORT ON DATA ANALYSES.—Not later  
24           than 4 years after the submission of the report  
25           under subsection (b)(1), and every 4 years there-

1 after, the Center shall submit to Congress and the  
2 Secretary a report that includes recommendations  
3 for improving the identification of health care dis-  
4 parities based on the analyses of data collected  
5 under subsection (c).

6 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not  
7 later than 2 years after the date on which benefits first  
8 become available as described in section 106(a), the Sec-  
9 retary shall implement the approaches identified in the re-  
10 port submitted under subsection (b)(1) for the ongoing,  
11 accurate, and timely collection and evaluation of data on  
12 health care disparities on the basis of race, ethnicity, na-  
13 tional origin, primary language use, age, disability, sex  
14 (including gender identity and sexual orientation), geog-  
15 raphy, or socioeconomic status.

16 **TITLE VI—HEALTH BUDGET;**  
17 **PAYMENTS; COST CONTAIN-**  
18 **MENT MEASURES**

19 **Subtitle A—Budgeting**

20 **SEC. 601. NATIONAL HEALTH BUDGET.**

21 (a) NATIONAL HEALTH BUDGET.—

22 (1) IN GENERAL.—By not later than September  
23 1 of each year, beginning with the year prior to the  
24 date on which benefits first become available as de-  
25 scribed in section 106(a), the Secretary shall estab-

1       lish a national health budget, which specifies a budg-  
2       et for the total expenditures to be made for covered  
3       health care items and services under this Act.

4               (2) DIVISION OF BUDGET INTO COMPONENTS.—  
5       The national health budget shall consist of the fol-  
6       lowing components:

7               (A) An operating budget.

8               (B) A capital expenditures budget.

9               (C) A special projects budget.

10              (D) Quality assessment activities under  
11       title V.

12              (E) Health professional education expendi-  
13       tures.

14              (F) Administrative costs, including costs  
15       related to the operation of regional offices.

16              (G) A reserve fund.

17              (H) Prevention and public health activities.

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

23              (A) that the operating budget allows for  
24       every participating provider in the Medicare for

1 All Program to meet the needs of their respec-  
2 tive patient populations;

3 (B) that the special projects budget is suf-  
4 ficient to meet the health care needs within  
5 areas described in paragraph (2)(C) through  
6 the construction, renovation, and staffing of  
7 health care facilities in a reasonable timeframe;

8 (C) a fair allocation for quality assessment  
9 activities; and

10 (D) that the health professional education  
11 expenditure component is sufficient to provide  
12 for the amount of health professional education  
13 expenditures sufficient to meet the need for cov-  
14 ered health care services.

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

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

1 (A) payments to institutional providers  
2 pursuant to section 611; and

3 (B) payments to individual providers pur-  
4 suant to section 612.

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

8 (A) the construction or renovation of  
9 health care facilities, excluding congregate or  
10 segregated facilities for individuals with disabil-  
11 ities who receive long-term care services and  
12 support; and

13 (B) major equipment purchases.

14 (7) SPECIAL PROJECTS BUDGET.—The special  
15 projects budget described in paragraph (2)(C) shall  
16 be used for the purposes of allocating funds for the  
17 construction of new facilities, major equipment pur-  
18 chases, and staffing in rural or medically under-  
19 served areas (as defined in section 330(b)(3) of the  
20 Public Health Service Act (42 U.S.C. 254b(b)(3))),  
21 including areas designated as health professional  
22 shortage areas (as defined in section 332(a) of the  
23 Public Health Service Act (42 U.S.C. 254e(a))), and  
24 to address health disparities, including racial, ethnic,  
25 national origin, primary language use, age, dis-

1 ability, sex (including gender identity and sexual ori-  
2 entation), geography, or socioeconomic health dis-  
3 parities.

4 (8) TEMPORARY WORKER ASSISTANCE.—

5 (A) IN GENERAL.—For up to 5 years fol-  
6 lowing the date on which benefits first become  
7 available as described in section 106(a), at least  
8 1 percent of the budget shall be allocated to  
9 programs providing assistance to workers who  
10 perform functions in the administration of the  
11 health insurance system, or related functions  
12 within health care institutions or organizations  
13 who may be affected by the implementation of  
14 this Act and who may experience economic dis-  
15 location as a result of the implementation of  
16 this Act.

17 (B) CLARIFICATION.—Assistance described  
18 in subparagraph (A) shall include wage replace-  
19 ment, retirement benefits, job training and  
20 placement, preferential hiring, and education  
21 benefits.

22 (9) RESERVE FUND.—The reserve fund de-  
23 scribed in paragraph (2)(G) shall be used to respond  
24 to the costs of an epidemic, pandemic, natural dis-

1        aster, or other such health emergency, or market-  
2        shift adjustments related to patient volume.

3            (10) SUPPLEMENTAL INDIAN HEALTH SERVICE  
4        ALLOCATION.—The Secretary shall annually deter-  
5        mine the need to provide an allotment of supple-  
6        mental funds to Indian Health Services, including  
7        payments to providers, capital expenditures, special  
8        projects, health professional education, administra-  
9        tive expenses, and prevention and public health ac-  
10       activities.

11       (b) DEFINITIONS.—In this section:

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

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

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

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

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

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

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



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

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

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

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

7 (4) INTERIM ADJUSTMENTS.—The regional di-  
8 rector shall consider a petition for adjustment of any  
9 payment under this section filed by an institutional  
10 provider at any time based on the following:

11 (A) Factors that led to increased costs for  
12 the institutional provider that can reasonably be  
13 considered to be unanticipated and out of the  
14 control of the institutional provider, such as—

15 (i) natural disasters;

16 (ii) outbreaks of epidemics or infec-  
17 tious diseases;

18 (iii) unexpected facility or equipment  
19 repairs or purchases;

20 (iv) significant and unexpected in-  
21 creases in pharmaceutical or medical device  
22 prices; and

23 (v) unanticipated increases in complex  
24 or high-cost patients or care needs.

1 (B) Changes in Federal or State law that  
2 result in a change in costs.

3 (C) Reasonable increases in labor costs, in-  
4 cluding salaries and benefits, and changes in  
5 collective bargaining agreements, prevailing  
6 wage, or local law.

7 (b) PAYMENT AMOUNT.—

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

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

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

21 (B) the actual expenditures of such pro-  
22 vider in such provider's most recent cost report  
23 under title XVIII of the Social Security Act for  
24 each item and service compared to—

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

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

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

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

15 (E) the provider's maximum capacity to  
16 provide items and services;

17 (F) education and prevention programs;

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

21 (i) an increase in primary or specialty  
22 care access;

23 (ii) efforts to decrease health care dis-  
24 parities in rural or medically underserved  
25 areas;

1 (iii) a response to emergent epidemic  
2 conditions;

3 (iv) an increase in complex or high-  
4 cost patients or care needs; or

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

8 (H) whether the provider is located in a  
9 high social vulnerability index community, zip  
10 code, or census track, or is a minority-serving  
11 provider; and

12 (I) any other factor determined appro-  
13 priate by the Secretary.

14 (3) LIMITATION.—Payment amounts negotiated  
15 pursuant to paragraph (1) may not—

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

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

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

24 (D) be used to pay or otherwise com-  
25 pensate any board member, executive, or ad-

1            administrator of the institutional provider who  
2            has any interest or relationship prohibited  
3            under section 301(b)(2) of this Act or disclosed  
4            under section 301 of this Act.

5            (4) LIMITATION ON COMPENSATION.—Com-  
6            pensation costs for any employee or any contractor  
7            or any subcontractor employee of an institutional  
8            provider receiving global budgets under this section  
9            shall meet the compensation cap established in sec-  
10          tion 702 of the Bipartisan Budget Act of 2013 (41  
11          U.S.C. 4304(a)(16)) and implementing regulations.

12          (5) REGIONAL NEGOTIATIONS PERMITTED.—  
13          Subject to section 614, a regional director may nego-  
14          tiate changes to an institutional provider’s global  
15          budget, including any adjustments to address un-  
16          foreseen market-shifts related to patient volume.

17          (c) BASELINE RATES AND ADJUSTMENTS.—

18          (1) IN GENERAL.—The Secretary shall use ex-  
19          isting prospective payment systems under title  
20          XVIII of the Social Security Act to serve as the  
21          comparative payment rate system in global budget  
22          negotiations described in subsection (b). The Sec-  
23          retary shall update such comparative payment rate  
24          systems annually.

1           (2) SPECIFICATIONS.—In developing the com-  
2           parative payment rate system, the Secretary shall  
3           use only the operating base payment rates under  
4           each such prospective payment systems with applica-  
5           ble adjustments.

6           (3) LIMITATION.—The comparative rate system  
7           established under this subsection shall not include  
8           the value-based payment adjustments and the cap-  
9           ital expenses base payment rates that may be in-  
10          cluded in such a prospective payment system.

11          (4) INITIAL YEAR.—In the first year that global  
12          budget payments under this Act are available to in-  
13          stitutional providers and for purposes of selecting a  
14          comparative payment rate system used during initial  
15          global budget negotiations for each institutional pro-  
16          vider, the Secretary shall take into account the ap-  
17          propriate prospective payment system from the most  
18          recent year under title XVIII of the Social Security  
19          Act to determine what operating base payment the  
20          institutional provider would have been paid for cov-  
21          ered items and services furnished the preceding year  
22          with applicable adjustments, excluding value-based  
23          payment adjustments, based on such prospective  
24          payment system.

1 (d) OPERATING EXPENSES.—For purposes of this  
2 title, “operating expenses” of a provider include the fol-  
3 lowing:

4 (1) The cost of all items and services associated  
5 with the provision of inpatient care and outpatient  
6 care, including the following:

7 (A) Wages and salary costs for physicians,  
8 nurses, and other health care practitioners em-  
9 ployed by an institutional provider, including  
10 mandatory minimum safe registered nurse-to-  
11 patient staffing ratios and optimal staffing lev-  
12 els for physicians and other healthcare workers.

13 (B) Wages and salary costs for all ancil-  
14 lary staff and services.

15 (C) Costs of all pharmaceutical products  
16 administered by health care clinicians at the in-  
17 stitutional provider’s facilities or through serv-  
18 ices provided in accordance with State licensing  
19 laws or regulations under which the institu-  
20 tional provider operates.

21 (D) Costs for infectious disease response  
22 preparedness, including maintenance of a 1-  
23 year or 365-day stockpile of personal protective  
24 equipment, occupational testing and surveil-



1 lance, medical services for occupational infec-  
2 tious disease exposure, and contact tracing.

3 (E) Purchasing and maintenance of med-  
4 ical devices, supplies, and other health care  
5 technologies, including diagnostic testing equip-  
6 ment.

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

9 (G) Costs of patient care, education, and  
10 prevention programs, including occupational  
11 health and safety programs, public health pro-  
12 grams, and necessary staff to implement such  
13 programs, for the continued education and  
14 health and safety of clinicians and other indi-  
15 viduals employed by the institutional provider.

16 (2) Administrative costs for the institutional  
17 provider.

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

20 (a) IN GENERAL.—In the case of a provider not de-  
21 scribed in section 611(a) (including those in group prac-  
22 tices who are not receiving payment on a salaried basis  
23 described in section 611(a)(3) and providers of home and  
24 community-based services), payment for items and serv-  
25 ices furnished under this Act for which payment is not

1 otherwise made under section 611 shall be made by the  
2 Secretary in amounts determined under the fee schedule  
3 established pursuant to subsection (b). Such payment  
4 shall be considered to be payment in full for such items  
5 and services, and a provider receiving such payment may  
6 not charge the individual receiving such item or service  
7 in any amount.

8 (b) FEE SCHEDULE.—

9 (1) ESTABLISHMENT.—Not later than 1 year  
10 after the date of the enactment of this Act, and in  
11 consultation with providers and regional office direc-  
12 tors, the Secretary shall establish a national fee  
13 schedule for items and services payable under this  
14 Act. The Secretary shall evaluate the effectiveness of  
15 the fee-for-service structure and update such fee  
16 schedule annually.

17 (2) AMOUNTS.—In establishing payment  
18 amounts for items and services under the fee sched-  
19 ule established under paragraph (1), the Secretary  
20 shall take into account—

21 (A) the amounts payable for such items  
22 and services under title XVIII of the Social Se-  
23 curity Act; and

24 (B) the expertise of providers and value of  
25 items and services furnished by such providers.

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

4           (d) PHYSICIAN PRACTICE REVIEW BOARD.—Each di-  
5     rector of a regional office, in consultation with representa-  
6     tives of physicians practicing in that region, shall establish  
7     and appoint a physician practice review board to assure  
8     quality, cost effectiveness, and fair reimbursements for  
9     physician-delivered items and services. The use of mecha-  
10    nisms that discriminate against people with disabilities is  
11    prohibited for use in any value or cost-effectiveness assess-  
12    ments.

13   **SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES**  
14                   **UNDER THE MEDICARE PHYSICIAN FEE**  
15                   **SCHEDULE.**

16           (a) STANDARDIZED AND DOCUMENTED REVIEW  
17    PROCESS.—Section 1848(c)(2) of the Social Security Act  
18    (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the  
19    end the following new subparagraph:

20                   “(P) STANDARDIZED AND DOCUMENTED  
21                   REVIEW PROCESS.—

22                           “(i) IN GENERAL.—Not later than one  
23                           year after the date of enactment of this  
24                           subparagraph, the Secretary shall estab-  
25                           lish, document, and make publicly avail-

1           able, in consultation with the Division of  
2           Primary Health Care, a standardized pro-  
3           cess for reviewing the relative values of phy-  
4           sicians' services under this paragraph.

5                   “(ii) MINIMUM REQUIREMENTS.—The  
6           standardized process shall include, at a  
7           minimum, methods and criteria for identi-  
8           fying services for review, prioritizing the  
9           review of services, reviewing stakeholder  
10          recommendations, and identifying addi-  
11          tional resources to be considered during  
12          the review process.”.

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

17                   “(x) PLANNED AND DOCUMENTED  
18          USE OF FUNDS.—For each fiscal year (be-  
19          ginning with the first fiscal year beginning  
20          on or after the date of enactment of this  
21          clause), the Secretary shall provide to Con-  
22          gress a written plan for using the funds  
23          provided under clause (ix) to collect and  
24          use information on physicians' services in

1                   the determination of relative values under  
2                   this subparagraph.”.

3           (c) INTERNAL TRACKING OF REVIEWS.—

4                   (1) IN GENERAL.—Not later than 1 year after  
5           the date of enactment of this Act, the Secretary  
6           shall submit to Congress a proposed plan for system-  
7           atically and internally tracking the Secretary’s re-  
8           view of the relative values of physicians’ services,  
9           such as by establishing an internal database, under  
10          section 1848(c)(2) of the Social Security Act (42  
11          U.S.C. 1395w-4(c)(2)), as amended by this section.

12                  (2) MINIMUM REQUIREMENTS.—The proposal  
13          shall include, at a minimum, plans and a timeline  
14          for achieving the ability to systematically and inter-  
15          nally track the following:

16                   (A) When, how, and by whom services are  
17                  identified for review.

18                   (B) When services are reviewed or re-  
19                  viewed or when new services are added.

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

22                   (D) When relative values are adjusted.

23                   (E) The rationale for final relative value  
24                  decisions.

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

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

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

8 (e) CONSULTATION WITH MEDICARE PAYMENT AD-  
9 VISORY COMMISSION.—

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

13 (A) in subparagraph (B)(i), by inserting  
14 “in consultation with the Medicare Payment  
15 Advisory Commission,” after “The Secretary,”;  
16 and

17 (B) in subparagraph (K)(i)(I), as amended  
18 by subsection (d)(2), by inserting “, in coordi-  
19 nation with the Medicare Payment Advisory  
20 Commission,” after “annually”.

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

24 (A) in subsection (b)(1)(A), by inserting  
25 the following before the semicolon at the end:

1 “and including coordinating with the Secretary  
2 in accordance with section 1848(c)(2) to sys-  
3 tematically review the relative values established  
4 for physicians’ services, identify potentially  
5 misvalued services, and propose adjustments to  
6 the relative values for physicians’ services”; and

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

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

15 “(Q) PERIODIC AUDIT BY THE COMP-  
16 TROLLER GENERAL.—

17 “(i) IN GENERAL.—The Comptroller  
18 General of the United States (in this sub-  
19 section referred to as the ‘Comptroller  
20 General’) shall periodically audit the review  
21 by the Secretary of relative values estab-  
22 lished under this paragraph for physicians’  
23 services.

24 “(ii) ACCESS TO INFORMATION.—The  
25 Comptroller General shall have unre-

1                   stricted access to all deliberations, records,  
2                   and data related to the activities carried  
3                   out under this paragraph, in a timely man-  
4                   ner, upon request.”.

5 **SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**  
6 **TURES; SPECIAL PROJECTS.**

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

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

18                   (1) marketing of the provider;

19                   (2) the profit or net revenue of the provider, or  
20 increasing the profit or net revenue of the provider;

21                   (3) incentive payments, bonuses, or other com-  
22 pensation based on patient utilization of items and  
23 services or any financial measure applied with re-  
24 spect to the provider (or any group practice, inte-  
25 grated health care delivery system, or other provider



1 with which the provider contracts or has a pecuniary  
2 interest), including any value-based payment or em-  
3 ployment-based compensation;

4 (4) any agreement or arrangement described in  
5 section 203(a)(4) of the Labor-Management Report-  
6 ing and Disclosure Act of 1959 (29 U.S.C.  
7 433(a)(4)); or

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

11 (c) PAYMENTS FOR CAPITAL EXPENDITURES.—

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

21 (2) PRIORITY.—The Secretary shall prioritize  
22 allocation of funding under paragraph (1) to  
23 projects that propose to use such funds to improve  
24 service in a medically underserved area (as defined  
25 in section 330(b)(3) of the Public Health Service

1 Act (42 U.S.C. 254b(b)(3))) or to address health  
2 disparities, including racial, ethnic, national origin,  
3 primary language use, age, disability, sex (including  
4 gender identity and sexual orientation), geography,  
5 or socioeconomic health disparities.

6 (3) LIMITATION.—The Secretary shall not  
7 grant funding for capital expenditures under this  
8 subsection for capital projects that are financed di-  
9 rectly or indirectly through the diversion of private  
10 or other non-Medicare for All Program funding that  
11 results in reductions in care to patients, including  
12 reductions in registered nursing staffing patterns  
13 and changes in emergency room or primary care  
14 services or availability.

15 (4) CAPITAL ASSETS NOT FUNDED BY THE  
16 MEDICARE FOR ALL PROGRAM.—Operating expenses  
17 and funds shall not be used by an institutional pro-  
18 vider receiving payment for capital expenditures  
19 under this subsection for a capital asset that was  
20 not funded by the Medicare for All program without  
21 the approval of the regional director or directors of  
22 the region or regions where the capital asset is lo-  
23 cated.

24 (d) PROHIBITION AGAINST CO-MINGLING OPER-  
25 ATING AND CAPITAL FUNDS.—Providers that receive pay-

1 ment under this title shall be prohibited from using, with  
2 respect to funds made available under this Act—

3 (1) funds designated for operating expenditures  
4 for capital expenditures or for profit; or

5 (2) funds designated for capital expenditures  
6 for operating expenditures.

7 (e) PAYMENTS FOR SPECIAL PROJECTS.—

8 (1) IN GENERAL.—The Secretary shall allocate  
9 to each regional director, from amounts made avail-  
10 able for special projects pursuant to section  
11 601(a)(2)(C), such sums determined appropriate by  
12 the Secretary for purposes of funding projects de-  
13 scribed in such section, including the construction,  
14 renovation, or staffing of health care facilities, in  
15 rural, underserved, or health professional or medical  
16 shortage areas within such region and to address  
17 health disparities, including racial, ethnic, national  
18 origin, primary language use, age, disability, sex, in-  
19 cluding gender identity and sexual orientation, geog-  
20 raphy, or socioeconomic health disparities. Each re-  
21 gional director shall, prior to distributing such funds  
22 in accordance with paragraph (2), present a budget  
23 describing how such funds will be distributed to the  
24 Secretary.

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

5           (f) PROHIBITION ON FINANCIAL INCENTIVE  
6 METRICS IN PAYMENT DETERMINATIONS.—The Sec-  
7 retary may not utilize any quality metrics or standards  
8 for the purposes of establishing provider payment meth-  
9 odologies, programs, modifiers, or adjustments for pro-  
10 vider payments under this title.

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

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

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

16           “(a) IN GENERAL.—There is established, in the Of-  
17 fice of the Secretary of Health and Human Services, an  
18 Office of Health Equity, to be headed by a Director, to  
19 ensure coordination and collaboration across the programs  
20 and activities of the Department of Health and Human  
21 Services with respect to ensuring health equity.

22           “(b) MONITORING, TRACKING, AND AVAILABILITY OF  
23 DATA.—

24           “(1) IN GENERAL.—In carrying out subsection  
25           (a), the Director of the Office of Health Equity shall

1 monitor, track, and make publicly available data  
2 on—

3 “(A) the disproportionate burden of dis-  
4 ease and death among people of color,  
5 disaggregated by race, major ethnic group,  
6 Tribal affiliation, national origin, primary lan-  
7 guage use, English proficiency status, immigra-  
8 tion status, length of stay in the United States  
9 age, disability, sex (including gender identity  
10 and sexual orientation), incarceration, home-  
11 lessness, geography, and socioeconomic status;

12 “(B) barriers to health, including such  
13 barriers relating to income, education, housing,  
14 food insecurity (including availability, access,  
15 utilization, and stability), employment status,  
16 working conditions, and conditions related to  
17 the physical environment (including pollutants  
18 and population density);

19 “(C) barriers to health care access, includ-  
20 ing—

21 “(i) lack of trust and awareness;

22 “(ii) lack of transportation;

23 “(iii) geography;

24 “(iv) hospital and service closures;

1                   “(v) lack of health care infrastructure  
2                   and facilities; and

3                   “(vi) lack of health care professional  
4                   staffing and recruitment;

5                   “(D) disparities in quality of care received,  
6                   including discrimination in health care settings  
7                   and the use of racially-biased practice guide-  
8                   lines and algorithms; and

9                   “(E) disparities in utilization of care.

10                  “(2) ANALYSIS OF CROSS-SECTIONAL INFORMA-  
11                  TION.—The Director of the Office of Health Equity  
12                  shall ensure that the data collection and reporting  
13                  process under paragraph (1) allows for the analysis  
14                  of cross-sectional information on people’s identities.

15                  “(c) POLICIES.—In carrying out subsection (a), the  
16                  Director of the Office of Health Equity shall develop, co-  
17                  ordinate, and promote policies that enhance health equity,  
18                  including by—

19                   “(1) providing recommendations on—

20                   “(A) cultural competence, implicit bias,  
21                   and ethics training with respect to health care  
22                   workers;

23                   “(B) increasing diversity in the health care  
24                   workforce; and

1                   “(C) ensuring sufficient health care profes-  
2                   sionals and facilities; and

3                   “(2) ensuring adequate public health funding at  
4                   the local and State levels to address health dispari-  
5                   ties.

6                   “(d) CONSULTATION.—In carrying out subsection  
7 (a), the Director of the Office of Health Equity, in coordi-  
8 nation with the Director of the Indian Health Service,  
9 shall consult with Indian Tribes and with Urban Indian  
10 organizations on data collection, reporting, and implemen-  
11 tation of policies.

12                   “(e) ANNUAL REPORT.—In carrying out subsection  
13 (a), the Director of the Office of Health Equity shall de-  
14 velop and publish an annual report on—

15                   “(1) statistics collected by the Office;

16                   “(2) proposed evidence-based solutions to miti-  
17                   gate health inequities; and

18                   “(3) health care professional staffing levels and  
19                   access to facilities.

20                   “(f) CENTRALIZED ELECTRONIC REPOSITORY.—In  
21 carrying out subsection (a), the Director of the Office of  
22 Health Equity shall—

23                   “(1) establish and maintain a centralized elec-  
24                   tronic repository to incorporate data collected across  
25                   Federal departments and agencies on race, ethnicity,

1 Tribal affiliation, national origin, primary language  
2 use, English proficiency status, immigration status,  
3 length of stay in the United States age, disability,  
4 sex (including gender identity and sexual orienta-  
5 tion), incarceration, homelessness, geography, and  
6 socioeconomic status; and

7 “(2) make such data available for public use  
8 and analysis.

9 “(g) PRIVACY.—Notwithstanding any other Federal  
10 or State law, no Federal or State official or employee or  
11 other entity shall disclose, or use, for any law enforcement  
12 or immigration purpose, any personally identifiable infor-  
13 mation (including with respect to an individual’s religious  
14 beliefs, practices, or affiliation, national origin, ethnicity,  
15 or immigration status) that is collected or maintained pur-  
16 suant to this section.”.

17 **SEC. 616. DIVISION OF PRIMARY CARE.**

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

21 **“SEC. 1713. DIVISION OF PRIMARY CARE.**

22 “(a) IN GENERAL.—There is established, in the Of-  
23 fice of Health Equity established under section 1712, a  
24 Division of Primary Health Care, to be headed by a Direc-  
25 tor, to ensure coordination and collaboration across the



1 programs and activities of the Department of Health and  
2 Human Services with respect to increasing access to high-  
3 quality primary health care, particularly in underserved  
4 areas and for underserved populations.

5 “(b) NATIONAL GOALS.—Not later than 1 year after  
6 the date of enactment of this section, the Director of the  
7 Division of Primary Health Care shall publish national  
8 goals—

9 “(1) to increase access to high-quality primary  
10 health care, particularly in underserved areas and  
11 for underserved populations; and

12 “(2) to address health disparities, including  
13 with respect to race, ethnicity, national origin  
14 (disaggregated by major ethnic group and Tribal af-  
15 filiation), primary language use, English proficiency  
16 status, immigration status, length of stay in the  
17 United States, age, disability, sex (including gender  
18 identity and sexual orientation), incarceration, home-  
19 lessness, geography, and socioeconomic status.

20 “(c) OTHER RESPONSIBILITIES.—In carrying out  
21 subsections (a) and (b), the Director of the Division of  
22 Primary Health Care shall—

23 “(1) coordinate, in consultation with the Sec-  
24 retary, health professional education policies and

1 goals to achieve the national goals published pursu-  
2 ant to subsection (b);

3 “(2) develop and maintain a system to monitor  
4 the number and specialties of individuals pursuing  
5 careers in, or practicing, primary health care  
6 through their health professional education, any  
7 postgraduate training, and professional practice;

8 “(3) develop, coordinate, and promote policies  
9 that expand the number of primary health care prac-  
10 titioners, registered nurses, mid-level practitioners,  
11 and dentists;

12 “(4) recommend appropriate training, technical  
13 assistance, and patient protection enhancements for  
14 primary care health professionals, including reg-  
15 istered nurses, to achieve uniform high quality and  
16 patient safety;

17 “(5) provide recommendations on targeted pro-  
18 grams and resources for Federally qualified health  
19 centers, rural health centers, community health cen-  
20 ters, and other community-based organizations;

21 “(6) provide recommendations for broader pa-  
22 tient referral to additional resources, not limited to  
23 health care, and collaboration with other organiza-  
24 tions and sectors that influence health outcomes;  
25 and

1           “(7) consult with the Secretary on the alloca-  
2           tion of the special projects budget under section  
3           601(a)(2)(C) of the Medicare for All Act of 2021.

4           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
5           tion shall be construed—

6           “(1) to preempt any provision of State law es-  
7           tablishing practice standards or guidelines for health  
8           care professionals, including professional licensing or  
9           practice laws or regulations; or

10           “(2) to require that any State impose additional  
11           educational standards or guidelines for health care  
12           professionals.”.

13   **SEC. 617. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**  
14                           **PROVED DEVICES AND EQUIPMENT.**

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

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

1 price period (as specified by the Secretary) for cov-  
2 ered drugs for eligible individuals under the Medi-  
3 care for All Program. In negotiating such prices  
4 under this section, the Secretary shall take into ac-  
5 count the following factors:

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

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

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

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

18 (2) FINALIZATION OF NEGOTIATED PRICE.—  
19 The negotiated price of each covered drug for a ne-  
20 gotiated price period shall be finalized not later than  
21 30 days before the first fiscal year in such nego-  
22 tiated price period.

23 (3) COMPETITIVE LICENSING AUTHORITY.—

24 (A) IN GENERAL.—Notwithstanding any  
25 exclusivity under clause (iii) or (iv) of section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           (b) APPROPRIATIONS INTO TRUST FUND.—



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

20           (2) CURRENT PROGRAM RECEIPTS.—

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

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

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

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

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

15 (iv) The purchased care component of  
16 the TRICARE program, under chapter 55  
17 of title 10, United States Code (other than  
18 amounts appropriated for the purchased  
19 care component of the TRICARE Overseas  
20 Program).

21 (v) The maternal and child health  
22 program (under title V of the Social Secu-  
23 rity Act), vocational rehabilitation pro-  
24 grams, programs for drug abuse and men-  
25 tal health services under the Public Health

1 Service Act, programs providing general  
2 hospital or medical assistance, and any  
3 other Federal program identified by the  
4 Secretary, in consultation with the Sec-  
5 retary of the Treasury, to the extent the  
6 programs provide for payment for health  
7 services the payment of which may be  
8 made under this Act.

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

22 (3) RESTRICTIONS SHALL NOT APPLY.—Any  
23 other provision of law in effect on the date of enact-  
24 ment of this Act restricting the use of Federal funds

1 for any reproductive health service shall not apply to  
2 monies in the Trust Fund.

3 (c) INCORPORATION OF PROVISIONS.—The provisions  
4 of subsections (b) through (i) of section 1817 of the Social  
5 Security Act (42 U.S.C. 1395i) shall apply to the Trust  
6 Fund under this section in the same manner as such pro-  
7 visions applied to the Federal Hospital Insurance Trust  
8 Fund under such section 1817, except that, for purposes  
9 of applying such subsections to this section, the “Board  
10 of Trustees of the Trust Fund” shall mean the “Sec-  
11 retary”.

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

1 **TITLE** **VIII—CONFORMING**  
2 **AMENDMENTS TO THE EM-**  
3 **PLOYEE RETIREMENT IN-**  
4 **COME SECURITY ACT OF 1974**

5 **SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**  
6 **TIVE OF BENEFITS UNDER THE MEDICARE**  
7 **FOR ALL PROGRAM; COORDINATION IN CASE**  
8 **OF WORKERS' COMPENSATION.**

9 (a) IN GENERAL.—Part 5 of subtitle B of title I of  
10 the Employee Retirement Income Security Act of 1974  
11 (29 U.S.C. 1131 et seq.) is amended by adding at the end  
12 the following new section:

13 **“SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**  
14 **CATIVE OF UNIVERSAL MEDICARE PROGRAM**  
15 **BENEFITS; COORDINATION IN CASE OF**  
16 **WORKERS' COMPENSATION.**

17 “(a) IN GENERAL.—Subject to subsection (b), no em-  
18 ployee benefit plan may provide benefits that duplicate  
19 payment for any items or services for which payment may  
20 be made under the Medicare for All Act of 2021.

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

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

1           “(1) the term ‘workers compensation carrier’  
2 means an insurance company that underwrite work-  
3 ers compensation medical benefits with respect to  
4 one or more employers and includes an employer or  
5 fund that is financially at risk for the provision of  
6 workers compensation medical benefits;

7           “(2) the term ‘workers compensation medical  
8 benefits’ means, with respect to an enrollee who is  
9 an employee subject to the workers compensation  
10 laws of a State, the comprehensive medical benefits  
11 for work-related injuries and illnesses provided for  
12 under such laws with respect to such an employee;  
13 and

14           “(3) the term ‘workers compensation services’  
15 means items and services included in workers com-  
16 pensation medical benefits and includes items and  
17 services (including rehabilitation services and long-  
18 term care services) commonly used for treatment of  
19 work-related injuries and illnesses.”.

20           (b) CONFORMING AMENDMENT.—Section 4(b) of the  
21 Employee Retirement Income Security Act of 1974 (29  
22 U.S.C. 1003(b)) is amended by adding at the end the fol-  
23 lowing: “Paragraph (3) shall apply subject to section  
24 522(b) (relating to reimbursement of the Medicare for All  
25 Program by workers compensation carriers).”.

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

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

4 **SEC. 802. APPLICATION OF CONTINUATION COVERAGE RE-**  
5 **QUIREMENTS UNDER ERISA AND CERTAIN**  
6 **OTHER REQUIREMENTS RELATING TO**  
7 **GROUP HEALTH PLANS.**

8 (a) IN GENERAL.—Part 6 of subtitle B of title I of  
9 the Employee Retirement Income Security Act of 1974  
10 (29 U.S.C. 1161 et seq.) shall apply only with respect to  
11 any employee health benefit plan that does not duplicate  
12 payments for any items or services for which payment may  
13 be made under the this Act.

14 (b) CONFORMING AMENDMENT.—Section 601 of part  
15 6 of subtitle B of title I of the Employee Retirement In-  
16 come Security Act of 1974 (19 U.S.C. 1161) is amended  
17 by adding the following subsection at the end:

18 “(c) Subsection (a) shall apply to any group health  
19 plan that does not duplicate payments for any items or  
20 services for which payment may be made under the Medi-  
21 care for All Act of 2021.”.

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

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

1                   **TITLE IX—ADDITIONAL**  
2                   **CONFORMING AMENDMENTS**

3   **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**  
4                   **PROGRAMS.**

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

7           (1) IN GENERAL.—Notwithstanding any other  
8 provision of law and with respect to an individual el-  
9 igible to enroll under this Act, subject to paragraphs  
10 (2) and (3)—

11           (A) no benefits shall be available under  
12 title XVIII of the Social Security Act for any  
13 item or service furnished beginning on the date  
14 that is 2 years after the date of the enactment  
15 of this Act;

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

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

24           (D) no payment shall be made to a State  
25 under section 1903(a) or 2105(a) of such Act



1 with respect to medical assistance or child  
2 health assistance for any item or service fur-  
3 nished on or after such date.

4 (2) TRANSITION.—In the case of inpatient hos-  
5 pital services and extended care services during a  
6 continuous period of stay which began before the ef-  
7 fective date of benefits under section 106, and which  
8 had not ended as of such date, for which benefits  
9 are provided under title XVIII of the Social Security  
10 Act, under a State plan under title XIX of such Act,  
11 or under a State child health plan under title XXI  
12 of such Act, the Secretary shall provide for continu-  
13 ation of benefits under such title or plan until the  
14 end of the period of stay.

15 (3) SCHOOL PROGRAMS.—All school related  
16 health programs, centers, initiatives, services, or  
17 other activities or work provided under title XIX or  
18 title XXI of the Social Security Act as of January  
19 1, 2019, shall be continued and covered by the Medi-  
20 care for All Program.

21 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-  
22 GRAM.—No benefits shall be made available under chapter  
23 89 of title 5, United States Code, with respect to items  
24 and services furnished to any individual eligible to enroll  
25 under this Act.

1 (c) TRICARE PROGRAM.—

2 (1) DIRECT CARE COMPONENT.—Nothing in  
3 this Act shall affect the eligibility of beneficiaries  
4 under chapter 55 of title 10, United States Code,  
5 who are entitled to receive care furnished at facilities  
6 of the uniformed services under the TRICARE pro-  
7 gram for such care.

8 (2) PURCHASED CARE COMPONENT.—

9 (A) IN GENERAL.—Except as provided in  
10 subparagraph (B), no benefits shall be made  
11 available under the purchased care component  
12 of the TRICARE program for items or services  
13 furnished to any individual eligible to enroll  
14 under this Act.

15 (B) TRICARE OVERSEAS.—During any  
16 period in which an individual is eligible for ben-  
17 efits under the TRICARE Overseas Program  
18 and is located in a TRICARE overseas region,  
19 the individual may receive benefits for items or  
20 services furnished to the individual under the  
21 purchased care component of such program  
22 during such period.

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

1           (1) IN GENERAL.—Nothing in this Act shall af-  
2           fect the eligibility of veterans for the medical bene-  
3           fits and services provided under title 38, United  
4           States Code, or of Indians for the medical benefits  
5           and services provided by or through the Indian  
6           Health Service.

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

10 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**  
11 **EXCHANGES.**

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

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

22           (a) Effective on the date described in section 106(a),  
23 the Federal programs related to pay for performance pro-  
24 grams and value-based purchasing shall terminate, and  
25 any other provision of law that relies upon participation

1 in or enrollment in such program shall cease to have force  
2 or effect. Programs that shall terminate include—

3 (1) the Merit-based Incentive Payment System  
4 established pursuant to subsection (q) of section  
5 1848 of the Social Security Act (42 U.S.C. 1395w–  
6 4(q));

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

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

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

18 (5) the following programs as established pur-  
19 suant to the following sections of the Patient Protec-  
20 tion and Affordable Care Act:

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

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

1 (C) Section 2706 (Pediatric Accountable  
2 Care Organization Demonstration Projects for  
3 the purposes of receiving incentive payments).

4 (D) Section 3002(b) (42 U.S.C. 1395w-  
5 4(a)(8)) (incentive payments for quality report-  
6 ing).

7 (E) Section 3001(a) (42 U.S.C.  
8 1395ww(o)) (Hospital Value-Based Purchas-  
9 ing).

10 (F) Section 3006 (value-based purchasing  
11 program for skilled nursing facilities and home  
12 health agencies).

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

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

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

21 (J) Section 3023 (42 U.S.C. 1395cc-4)  
22 (National Pilot Program on Payment Bun-  
23 dling).

1 (K) Section 3024 (42 U.S.C. 1395cc–5)  
2 (Independence at home demonstration pro-  
3 gram).

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

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

9 **TITLE X—TRANSITION**  
10 **Subtitle A—Medicare for All Tran-**  
11 **sition Over 2 Years and Transi-**  
12 **tional Buy-In Option**

13 **SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO**  
14 **YEARS.**

15 Title XVIII of the Social Security Act (42 U.S.C.  
16 1395c et seq.) is amended by adding at the end the fol-  
17 lowing new section:

18 **“SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2**  
19 **YEARS.**

20 **“(a) TRANSITION.—**

21 **“(1) IN GENERAL.—**Every individual who meets  
22 the requirements described in paragraph (3) shall be  
23 eligible to enroll in the Medicare for All Program  
24 under this section during the transition period start-

1       ing one year after the date of enactment of the  
2       Medicare for All Act of 2021.

3           “(2) BENEFITS.—An individual enrolled under  
4       this section is entitled to the benefits established  
5       under title II of the Medicare for All Act of 2021.

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

9           “(A) The individual meets the eligibility re-  
10       quirements established by the Secretary under  
11       title I of the Medicare for All Act of 2021.

12          “(B) The individual has attained the appli-  
13       cable year of age, or is currently enrolled in  
14       Medicare at the time of the transition to Medi-  
15       care for All.

16          “(4) APPLICABLE YEAR OF AGE DEFINED.—  
17       For purposes of this section, the term ‘applicable  
18       year of age’ means one year after the date of enact-  
19       ment of the Medicare for All Act of 2021, the age  
20       of 55 or older, the age 18 or younger.

21          “(b) ENROLLMENT; COVERAGE.—The Secretary shall  
22       establish enrollment periods and coverage under this sec-  
23       tion consistent with the principles for establishment of en-  
24       rollment periods and coverage for individuals under other  
25       provisions of this title. The Secretary shall establish such

1 periods so that coverage under this section shall first begin  
2 on January 1 of the year on which an individual first be-  
3 comes eligible to enroll under this section.

4 “(c) SATISFACTION OF INDIVIDUAL MANDATE.—For  
5 purposes of applying section 5000A of the Internal Rev-  
6 enue Code of 1986, the coverage provided under this sec-  
7 tion constitutes minimum essential coverage under sub-  
8 section (f)(1)(A)(i) of such section 5000A.

9 “(d) CONSULTATION.—In promulgating regulations  
10 to implement this section, the Secretary shall consult with  
11 interested parties, including groups representing bene-  
12 ficiaries, health care providers, employers, and insurance  
13 companies.”.

14 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**  
15 **TION BUY-IN.**

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



1 (b) ADMINISTERING THE MEDICARE TRANSITION  
2 BUY-IN.—

3 (1) ADMINISTRATOR.—The Administrator shall  
4 administer the Medicare Transition buy-in in accord-  
5 ance with this section.

6 (2) APPLICATION OF ACA REQUIREMENTS.—  
7 Consistent with this section, the Medicare Transition  
8 buy-in shall comply with requirements under title I  
9 of the Patient Protection and Affordable Care Act  
10 (and the amendments made by that title) and title  
11 XXVII of the Public Health Service Act (42 U.S.C.  
12 300gg et seq.) that are applicable to qualified health  
13 plans offered through the Exchanges, subject to the  
14 limitation under subsection (e)(2).

15 (3) OFFERING THROUGH EXCHANGES.—The  
16 Medicare Transition buy-in shall be made available  
17 only through the Exchanges, and shall be available  
18 to individuals wishing to enroll and to qualified em-  
19 ployers (as defined in section 1312(f)(2) of the Pa-  
20 tient Protection and Affordable Care Act (42 U.S.C.  
21 18032)) who wish to make such plan available to  
22 their employees.

23 (4) ELIGIBILITY TO PURCHASE.—Any United  
24 States resident may enroll in the Medicare Transi-  
25 tion buy-in.

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

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

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

9 (d) PROVIDERS AND REIMBURSEMENT RATES.—

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

18 (2) PRESCRIPTION DRUGS.—Any payment rate  
19 under this subsection for a prescription drug shall be  
20 at the prices negotiated under section 616 of this  
21 Act.

22 (3) PARTICIPATING PROVIDERS.—

23 (A) IN GENERAL.—A health care provider  
24 that is a participating provider of services or  
25 supplier under the Medicare program under

1 title XVIII of the Social Security Act (42  
2 U.S.C. 1395 et seq.) or under a State Medicaid  
3 plan under title XIX of such Act (42 U.S.C.  
4 1396 et seq.) on the date of enactment of this  
5 Act shall be a participating provider in the  
6 Medicare Transition buy-in.

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

14 (e) PREMIUMS.—

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

18 (A) may vary according to family or indi-  
19 vidual coverage, age, and tobacco status (con-  
20 sistent with clauses (i), (iii), and (iv) of section  
21 2701(a)(1)(A) of the Public Health Service Act  
22 (42 U.S.C. 300gg(a)(1)(A))); and

23 (B) shall take into account the cost-shar-  
24 ing reductions and premium tax credits which  
25 will be available with respect to the plan under

1 section 1402 of the Patient Protection and Af-  
2 fordable Care Act (42 U.S.C. 18071) and sec-  
3 tion 36B of the Internal Revenue Code of 1986,  
4 as amended by subsection (g).

5 (2) LIMITATION.—Variation in premium rates  
6 of the Medicare Transition buy-in by rating area, as  
7 described in clause (ii) of section 2701(a)(1)(A)(iii)  
8 of the Public Health Service Act (42 U.S.C.  
9 300gg(a)(1)(A)) is not permitted.

10 (f) TERMINATION.—This section shall cease to have  
11 force or effect on the effective date described in section  
12 106(a).

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

14 (1) PREMIUM ASSISTANCE TAX CREDITS.—

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

23 “(C) SPECIAL RULES FOR MEDICARE  
24 TRANSITION BUY-IN ENROLLEES.—

1           “(i) IN GENERAL.—In the case of a  
2 taxpayer who is covered, or whose spouse  
3 or dependent (as defined in section 152) is  
4 covered, by the Medicare Transition buy-in  
5 established under section 1002(a) of the  
6 Medicare for All Act of 2021 for all  
7 months in the taxable year, subparagraph  
8 (A) shall be applied without regard to ‘but  
9 does not exceed 400 percent’.

10           “(ii) ENROLLEES IN MEDICAID NON-  
11 EXPANSION STATES.—In the case of a tax-  
12 payer residing in a State which (as of the  
13 date of the enactment of the Medicare for  
14 All Act of 2021) does not provide for eligi-  
15 bility under clause (i)(VIII) or (ii)(XX) of  
16 section 1902(a)(10)(A) of the Social Secu-  
17 rity Act for medical assistance under title  
18 XIX of such Act (or a waiver of the State  
19 plan approved under section 1115) who is  
20 covered, or whose spouse or dependent (as  
21 defined in section 152) is covered, by the  
22 Medicare Transition buy-in established  
23 under section 1002(a) of the Medicare for  
24 All Act of 2021 for all months in the tax-  
25 able year, subparagraphs (A) and (B) shall

1 be applied by substituting ‘0 percent’ for  
2 ‘100 percent’ each place it appears.”.

3 (B) PREMIUM ASSISTANCE AMOUNTS FOR  
4 TAXPAYERS ENROLLED IN MEDICARE TRANSI-  
5 TION BUY-IN.—

6 (i) IN GENERAL.—Subparagraph (A)  
7 of section 36B(b)(3) of such Code is  
8 amended—(I) by redesignating clause (ii)  
9 as clause (iii), (II) by striking “clause (ii)”  
10 in clause (i) and inserting “clauses (ii) and  
11 (iii)”, and (III) by inserting after clause (i)  
12 the following new clause:

13 “(ii) SPECIAL RULES FOR TAXPAYERS  
14 ENROLLED IN MEDICARE TRANSITION BUY-  
15 IN.—In the case of a taxpayer who is cov-  
16 ered, or whose spouse or dependent (as de-  
17 fined in section 152) is covered, by the  
18 Medicare Transition buy-in established  
19 under section 1002(a) of the Medicare for  
20 All Act of 2021 for all months in the tax-  
21 able year, the applicable percentage for  
22 any taxable year shall be determined in the  
23 same manner as under clause (i), except  
24 that the following table shall apply in lieu  
25 of the table contained in such clause:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent .....	2.00	2.00
100 percent up to 138 percent .....	2.04	2.04
138 percent up to 150 percent .....	3.06	4.08
150 percent and above .....	4.08	5.00.”.

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

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

12                                 (A) by inserting “, or in the Medicare  
13                                 Transition buy-in established under section  
14                                 1002(a) of the Medicare for All Act of 2021,”  
15                                 after “coverage” in paragraph (1);

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

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

1 “(1) IN GENERAL.—In this section”;

2 (D) by striking the flush language; and

3 (E) by adding at the end the following new  
4 paragraph:

5 “(2) SPECIAL RULES.—

6 “(A) INDIVIDUALS LAWFULLY PRESENT.—

7 In the case of an individual described in section  
8 36B(c)(1)(B) of the Internal Revenue Code of  
9 1986, the individual shall be treated as having  
10 household income equal to 100 percent of the  
11 poverty line for a family of the size involved for  
12 purposes of applying this section.

13 “(B) MEDICARE TRANSITION BUY-IN EN-  
14 ROLLEES IN MEDICAID NON-EXPANSION  
15 STATES.—In the case of an individual residing  
16 in a State which (as of the date of the enact-  
17 ment of the Medicare for All Act of 2021) does  
18 not provide for eligibility under clause (i)(VIII)  
19 or (ii)(XX) of section 1902(a)(10)(A) of the So-  
20 cial Security Act for medical assistance under  
21 title XIX of such Act (or a waiver of the State  
22 plan approved under section 1115) who enrolls  
23 in such Medicare Transition buy-in, the pre-  
24 ceding sentence, paragraph (1)(B), and para-  
25 graphs (1)(A)(i) and (2)(A) of subsection (c)





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

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

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

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

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

21 (b) CONFORMING AMENDMENTS.—

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

24                   (A) striking subsections (e)(1)(B), (f), and  
25                   (h); and

1 (B) redesignating subsections (g) and (i)  
2 as subsections (f) and (g), respectively.

3 (2) MEDICARE DESCRIPTION.—Section 1811(2)  
4 of the Social Security Act (42 U.S.C. 1395c(2)) is  
5 amended by striking “have been entitled for not less  
6 than 24 months” and inserting “are entitled”.

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

11 (4) RAILROAD RETIREMENT SYSTEM.—Section  
12 7(d)(2)(ii) of the Railroad Retirement Act of 1974  
13 (45 U.S.C. 231f(d)(2)(ii)) is amended—

14 (A) by striking “has been entitled to an  
15 annuity” and inserting “is entitled to an annu-  
16 ity”;

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

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

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to insurance benefits under title  
23 XVIII of the Social Security Act with respect to items and  
24 services furnished in months beginning after December 1  
25 following the date of enactment of this Act, and before

1 the date that is 2 years after the date of the enactment  
2 of such Act.

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

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

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

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

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

1           (2) During the transition period of the Medi-  
2           care for All Act group health plans and health insur-  
3           ance issuers offering group or individual health in-  
4           surance coverage shall not—

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

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

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

## 23           **TITLE XI—MISCELLANEOUS**

### 24           **SEC. 1101. DEFINITIONS.**

25           In this Act—

1           (1) the term “global budget” means the pay-  
2           ment negotiated between an institutional provider  
3           and as described in section 611(b);

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

7           (3) the term “individual provider” means a sup-  
8           plier (as defined in section 1861(d) of such Act (42  
9           U.S.C. 1395x(d)));

10          (4) the term “institutional provider” means—

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

13           (B) hospitals as defined in section 1861(e)  
14           of the Social Security Act (42 U.S.C.  
15           1395x(e)), and any outpatient settings or clinics  
16           operating within a hospital license or any set-  
17           ting or clinic that provides outpatient hospital  
18           services;

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

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

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

4 (F) independent dialysis facilities and inde-  
5 pendent end-stage renal disease facilities as de-  
6 scribed in 42 CFR 413.174(b);

7 (5) the term “medically necessary or appro-  
8 priate” means the health care items and services or  
9 supplies that are needed or appropriate to prevent,  
10 diagnose, or treat an illness, injury, condition, dis-  
11 ease, or its symptoms for an individual and are de-  
12 termined to be necessary or appropriate for such in-  
13 dividual by the physician or other health care profes-  
14 sional treating such individual, after such profes-  
15 sional performs an assessment of such individual’s  
16 condition, in a manner that meets—

17 (A) the scope of practice, licensing, and  
18 other law of the State in which the individual  
19 receiving such items and services is located; and

20 (B) appropriate standards established by  
21 the Secretary for purposes of carrying out this  
22 Act;

23 (6) the term “provider” means an institutional  
24 provider or a supplier (as defined in section 1861(d)  
25 of such Act (42 U.S.C. 1395x(d)) if the reference to

1 “this title” were a reference to the Medicare for All  
2 Program);

3 (7) the term “Secretary” means the Secretary  
4 of Health and Human Services;

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

8 (9) the term “TRICARE Overseas Program”  
9 means the element of the TRICARE program ad-  
10 ministered by International SOS (or such successor  
11 administrator) under which care and health benefits  
12 are furnished to TRICARE beneficiaries located in  
13 a TRICARE overseas region;

14 (10) the term “TRICARE program” has the  
15 meaning given such term in section 1072 of title 10,  
16 United States Code;

17 (11) the term “uniformed services” has the  
18 meaning given such term in section 101 of title 10,  
19 United States Code; and

20 (12) the term “United States” shall include the  
21 States, the District of Columbia, and the territories  
22 of the United States.

23 **SEC. 1102. RULES OF CONSTRUCTION.**

24 (a) IN GENERAL.—A State or local government may  
25 set additional standards or apply other State or local laws



1 with respect to eligibility, benefits, and minimum provider  
2 standards, only if such State or local standards—

3 (1) provide equal or greater eligibility than is  
4 available under this Act;

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

7 (3) do not reduce access to benefits under this  
8 Act;

9 (4) allow for the effective exercise of the profes-  
10 sional judgment of physicians or other health care  
11 professionals; and

12 (5) are otherwise consistent with this Act.

13 (b) RELATION TO STATE LICENSING LAW.—Nothing  
14 in this Act shall be construed to preempt State licensing,  
15 practice, or educational laws or regulations with respect  
16 to health care professionals and health care providers, for  
17 such professionals and providers who practice in that  
18 State.

19 (c) APPLICATION TO STATE AND FEDERAL LAW ON  
20 WORKPLACE RIGHTS.—Nothing in this Act shall be con-  
21 strued to diminish or alter the rights, privileges, remedies,  
22 or obligations of any employee or employer under any Fed-  
23 eral or State law or regulation or under any collective bar-  
24 gaining agreement.

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

7 **SEC. 1103. NO USE OF RESOURCES FOR LAW ENFORCE-**  
8 **MENT OF CERTAIN REGISTRATION REQUIRE-**  
9 **MENTS.**

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