[118H3421]

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(Original Signature of Member)

119TH CONGRESS
1ST SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

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

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

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

SEC. 102. UNIVERSAL COVERAGE.

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

(b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary may make eligible for benefits for health care services under this Act other individuals not described in subsection (a), and regulate the eligibility of such individuals, to ensure that every person in the United States has access to health care. In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtain-

ing health care items and services provided under the program established under this Act.

SEC. 103. FREEDOM OF CHOICE.

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

SEC. 104. NON-DISCRIMINATION.

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

(b) CLAIMS OF DISCRIMINATION.—

(1) IN GENERAL.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of subsection (a).

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

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.

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

bilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing in this title (or an amendment to this title) shall be construed to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

SEC. 105. ENROLLMENT.

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

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States (or upon establishment of residency in the United States);

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

(3) include a process for the enrollment of individuals made eligible for health care services under section 102(b).

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

poses of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

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

(b) COVERAGE FOR CERTAIN INDIVIDUALS.—

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

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

(B) has attained the age of 55 as of the date that is 1 year after the date of the enactment of this Act,

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

(2) OPTION TO CONTINUE IN OTHER COVERAGE DURING TRANSITION PERIOD.—Any person who is eligible to receive benefits as described in paragraph (1) may opt to maintain any coverage described in section 901, private health insurance coverage, or coverage offered pursuant to subtitle A of title X

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

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

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

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

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

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

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

SEC. 201. COMPREHENSIVE BENEFITS.

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

benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

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

(2) Ambulatory patient services.

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

(4) Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products, and all contraceptive items approved by the Food and Drug Administration.

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

(6) Laboratory and diagnostic services.

(7) Comprehensive reproductive care, including abortion, contraception, and assistive reproductive technology.

(8) Maternity and newborn care.

(9) Comprehensive gender affirming health care.

(10) Oral health, audiology, and vision services.

(11) Rehabilitative and habilitative services and devices.

(12) Emergency services and transportation.

(13) Early and periodic screening, diagnostic, and treatment services, as described in sections 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)).

(14) Necessary transportation to receive health care services for persons with disabilities, older individuals with functional limitations, or low-income individuals (as determined by the Secretary).

(15) Long-term care services and support (as described in section 204).

(16) Hospice care.

(17) Services provided by a licensed marriage and family therapist or a licensed mental health counselor.

(18) Any service described in a preceding paragraph that is furnished via telehealth, to the extent practical.

(b) REVISION.—The Secretary shall, at least annually, and on a regular basis, evaluate whether the benefits

package should be improved to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to Congress regarding any such improvements. Such recommendations may not include a recommendation to eliminate any benefit.

(c) HEARINGS.—

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

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

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

(B) with full recognition of the constitutional right of either House to change such rules (so far as relating to the procedure in

such House) at any time, in the same manner, and to the same extent as in the case of any other rule of the House.

(d) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

(1) IN GENERAL.—In carrying out subsection (b), the Secretary shall consult with the persons described in paragraph (2) with respect to—

(A) identifying specific complementary and integrative medicine practices that are appropriate to include in the benefits package; and

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

(2) CONSULTATION.—In accordance with paragraph (1), the Secretary shall consult with—

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

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and alternative medicine and the in-

tegration of such practices into the delivery of health care;

(D) nationally recognized providers of complementary and integrative medicine; and

(E) such other officials, entities, and individuals with expertise on complementary and integrative medicine as the Secretary determines appropriate.

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

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

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

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

(c) NO PRIOR AUTHORIZATION.—Benefits provided under this Act shall be covered without any need for any

prior authorization determination and without any limitation applied through the use of step therapy protocols.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Benefits for items and services are not available under this Act unless the items and services meet the standards developed by the Secretary pursuant to section 201(a).

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

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

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

(c) APPLICATION OF PRACTICE GUIDELINES.—

(1) IN GENERAL.—In the case of items and services for which the Department of Health and

Human Services has recognized a national practice guideline, such items and services shall be deemed to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline. For purposes of this subsection, an item or service not provided in accordance with a practice guideline shall be deemed to have been provided in accordance with the guideline if the health care provider providing the item or service—

(A) exercised appropriate professional judgment in accordance with the laws and requirements of the State in which such item or service is furnished in deviating from the guideline;

(B) acted in the best interest of the individual receiving the item or service; and

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

(2) OVERRIDE OF STANDARDS.—

(A) IN GENERAL.—An individual's treating physician or other health care professional authorized to exercise independent professional judgment in implementing a patient's medical or nursing care plan in accordance with the scope of practice, licensure, and other law of

the State where items and services are to be furnished may override practice standards established pursuant to section 201(a) or practice guidelines described in paragraph (1), including such standards and guidelines that are implemented by a provider through the use of health information technology, such as electronic health record technology, clinical decision support technology, and computerized order entry programs.

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

(i) consistent with such physician's, nurse's, or health care professional's determination of medical necessity and appropriateness or nursing assessment;

(ii) in the best interests of the individual; and

(iii) consistent with the individual's wishes.

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

(a) IN GENERAL.—Subject to the other provisions of this Act, individuals enrolled for benefits under this Act

are entitled to the following long-term services and supports and to have payment made by the Secretary to an eligible provider for such services and supports if medically necessary and appropriate and in accordance with the standards established in this Act, for maintenance of health or for care, services, diagnosis, treatment, or rehabilitation that is related to a medically determinable condition, whether physical or mental, of health, injury, or age that—

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

(2) requires a similar need of assistance in performing instrumental activities of daily living.

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

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

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

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

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

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

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

(6) be provided with the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the individual's needs;

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

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

(9) ensure that long-term services and supports provide recipient's the option of self-direction of services from either the recipient or care coordinators of the recipient's choosing.

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

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

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

(3) groups that represent the diversity of the population of people living with disabilities, including racial, ethnic, national origin, primary language use, age, sex, including gender identity and sexual orientation, geographical, and socioeconomic diversity;

(4) providers of long-term services and supports, including family attendants and family caregivers, and members of organized labor;

(5) disability rights organizations; and

(6) relevant academic institutions and researchers.

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

(f) DEFINITIONS.—In this section:

(1) The term ''long-term services and supports'' means long-term care, treatment, maintenance, or services needed to support the activities of daily living and instrumental activities of daily living, including home and community-based services and any additional services and supports identified by the Secretary to support people with disabilities to live, work, and participate in their communities.

(2) The term ''activities of daily living'' means basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(3) The term ''instrumental activities of daily living'' means activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone

or other media, and traveling around and participating in the community.

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

TITLE III—PROVIDER PARTICIPATION

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

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

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

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

(3) meets, as applicable, such other qualifications and conditions with respect to a provider of services under title XVIII of the Social Security Act

as described in section 1866 of the Social Security Act (42 U.S.C. 1395cc).

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

(A) Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 104(a). Nothing in this subparagraph shall be construed as requiring the provision of a type or class of items or services that are outside the scope of the provider's normal practice.

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

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

(i) quality review by designated entities;

(ii) making payments under this Act, including the examination of records as may be necessary for the verification of information on which such payments are based;

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Secretary may specify.

(D) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider that has had a participation agreement under this subsection terminated for cause. The Secretary may authorize such employment or use on a case-by-case basis.

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

(F) In the case of an institutional provider paid pursuant to section 611, the provider agrees to submit information and any other required supporting documentation as may be reasonably required by the Secretary within 30 days after the date of providing such items and services and in accordance with the uniform reporting standards established under section 401(b)(1), including information on a quarterly basis that—

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

(ii) describes items and services furnished with respect to specific individuals.

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

(i) to disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations under title VI or for meeting any

other payment, documentation, or data collection requirements under this Act; and

(ii) not to use any such system or index to establish financial incentives or disincentives for health care professionals, or that is proprietary, interferes with the medical or nursing process, or is designed to increase the amount or number of payments.

(H) The provider complies with the duty of provider ethics and reporting requirements described in paragraph (2).

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

(2) PROVIDER DUTY OF ETHICS.—Each health care provider, including institutional providers, has a duty to advocate for and to act in the exclusive interest of each individual under the care of such pro-

vider according to the applicable legal standard of care, such that no financial interest or relationship impairs any health care provider's ability to furnish necessary and appropriate care to such individual. To implement the duty established in this paragraph, the Secretary shall—

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

(B) prohibit participating providers, spouses, and immediate family members of participating providers, from accepting or entering into any arrangement for any bonus, incentive payment, profit-sharing, or compensation based on patient utilization or based on financial outcomes of any other provider or entity; and

(C) prohibit participating providers or any board member or representative of such provider from serving as board members for or receiving any compensation, stock, or other financial investment in an entity that contracts with or provides items or services (including pharmaceutical products and medical devices or equipment) to such provider.

(3) TERMINATION OF PARTICIPATION AGREEMENT.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

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

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

(iii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Secretary terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

(C) PROVIDER PROTECTIONS.—

(i) PROHIBITION.—The Secretary may not terminate a participation agreement or in any other way discriminate against, or cause to be discriminated against, any covered provider or authorized representative of the provider, on account of such provider or representative—

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

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

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

(IV) objecting to, or refusing to participate in, any activity, policy, practice, or assigned task that the provider or representative reasonably believes to be in violation of any provision of this Act (including any amendment made by this Act), or any order, rule, regulation, standard, or ban

under this Act (including any amendment made by this Act).

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

(c) WHISTLEBLOWER PROTECTIONS.—

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

(A) notified the Secretary or the employee's employer of any alleged violation of this title, including communications related to carrying out the employee's job duties;

(B) refused to engage in any practice made unlawful by this title, if the employee has identified the alleged illegality to the employer;

(C) testified before or otherwise provided information relevant for Congress or for any

Federal or State proceeding regarding any provision (or proposed provision) of this title;

(D) commenced, caused to be commenced, or is about to commence or cause to be commenced a proceeding under this title;

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

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

(2) ENFORCEMENT ACTION.—Any employee covered by this section who alleges discrimination by an employer in violation of paragraph (1) may bring an action, subject to the statute of limitations in the anti-retaliation provisions of the False Claims Act and the rules and procedures, legal burdens of proof, and remedies applicable under the employee protections provisions of the Surface Transportation Assistance Act.

(3) APPLICATION.—

(A) Nothing in this subsection shall be construed to diminish the rights, privileges, or remedies of any employee under any Federal or

State law or regulation, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)), or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

(B) Nothing in this subsection shall be construed to preempt or diminish any other Federal or State law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)).

(4) DEFINITIONS.—In this subsection:

(A) EMPLOYER.—The term ''employer'' means any person engaged in profit or nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations,

or trustees, and subject to liability for violating the provisions of this Act.

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

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

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

(1) the requirements of such State's law to furnish such items and services; and

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

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

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

(2) entities that are currently approved to coordinate care plans under the Medicare Advantage

program established in part C of title XVIII of the Social Security Act (42 U.S.C. 1851 et seq.) but do not directly provide items and services of such care plans.

(c) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of items and services provided under this Act and to monitor efforts by States to ensure the quality of such items and services. A State may establish additional minimum standards which providers shall meet with respect to items and services provided in such State.

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

(A) adequacy and quality of facilities;

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

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

(D) comprehensiveness of service;

(E) continuity of service;

(F) patient waiting time, access to services, and preferences; and

(G) performance standards, including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation.

(3) TRANSITION IN APPLICATION.—If the Secretary provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) ABILITY TO PROVIDE SERVICES.—With respect to any entity or provider certified to provide items and services described in section 201(a)(7), the Secretary may not prohibit such entity or provider from participating for reasons other than such entity's or provider's ability to provide such items and services.

(d) FEDERAL PROVIDERS.—Any provider qualified to provide health care items and services through the Department of Veterans Affairs, the Indian Health Service, or the uniformed services (with respect to the direct care component of the TRICARE Program) is a qualifying provider under this section with respect to any individual who qualifies for such items and services under applicable Federal law.

SEC. 303. USE OF PRIVATE CONTRACTS.

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

(b) PARTICIPATING PROVIDERS.—

(1) PRIVATE CONTRACTS FOR COVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may not bill or enter into any private contract with any individual eligible for

benefits under the Act for any item or service that is a benefit under this Act.

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

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

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

(C) the provider receives—

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

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

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

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

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

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

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

(ii) agrees to be responsible for payment of such items or services and understands that no reimbursement will be provided under this Act for such items or services;

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

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

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

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

(B) state that the provider will not submit any claim under this Act for any noncovered item or service provided to any individual enrolled under this Act; and

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

(5) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (4) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (2) with respect to such affidavit—

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

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

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

(6) PRIVATE CONTRACTS FOR INELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may bill or enter into a private contract with any individual ineligible for benefits under the Act for any item or service.

(c) NONPARTICIPATING PROVIDERS.—

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

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services described in paragraph (1) shall—

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

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

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

(i) acknowledges that the individual has the right to have such items or services provided by other providers for whom payment would be made under this Act;

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

(iii) agrees to be responsible for payment of such items or services and under-

stands that no reimbursement will be provided under this Act for such items or services;

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

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

(3) AFFIDAVIT.—A provider who enters into a contract described in paragraph (1) shall have in effect during the period any item or service is to be provided pursuant to the contract an affidavit that shall—

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

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

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

(4) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (3) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (1) with respect to such affidavit—

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

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

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

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

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

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

(E) levels of funding;

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

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

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

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

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

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Secretary in accordance with section 553 of title 5, United States Code.

(3) ACCESSIBILITY.—The Secretary shall have the obligation to ensure the timely and accessible provision of items and services that all eligible individuals are entitled to under this Act.

(b) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and services, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible

without compromising patient privacy, health outcome measures used under this Act, and to the maximum extent feasible without excessively burdening providers, a description of the standards and qualifications, levels of finding, and methods described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REQUIRED DATA DISCLOSURES.—In establishing reporting requirements and standards under subparagraph (A), the Secretary shall require a provider with an agreement in effect under section 301 to disclose to the Secretary, in a time and manner specified by the Secretary, the following (as applicable to the type of provider):

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

(ii) Annual financial data that includes information on employees (including

the number of employees, hours worked, and wage information) by job title and by each patient care unit or department within each facility (including outpatient units or departments); the number of registered nurses per staffed bed by each such unit or department; information on the dollar value and annual spending (including purchases, upgrades, and maintenance) for health information technology; and risk-adjusted and raw patient outcome data (including data on medical, surgical, obstetric, and other procedures).

(C) REPORTS.—The Secretary shall regularly analyze information reported to the Secretary and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

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

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

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

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

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

(I) Differences in the health status of the populations of the different States, including by racial, ethnic, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographical, and income characteristics;

(J) Progress on quality and outcome measures, and long-range plans and goals for achievements in such areas.

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

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

(M) Opportunities for improvements under this Act.

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

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

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

(C) develop methodological standards for policymaking.

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an audit of the Department of Health and Human Services every fifth fiscal year following the effective date of this Act to determine the effectiveness of the program in carrying out the duties under subsection (a).

(2) REPORTS.—The Comptroller General of the United States shall submit a report to Congress concerning the results of each audit conducted under this subsection.

SEC. 402. CONSULTATION.

The Secretary shall consult with Federal agencies, Indian tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic health centers, consumer groups, and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines, consistent with the provisions of section 203(c), developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 403. REGIONAL ADMINISTRATION.

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

of, tertiary care facilities, equipment, and services by individuals enrolled under this Act. Wherever possible, the Secretary shall incorporate regional offices of the Centers for Medicare & Medicaid Services for this purpose.

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

(1) one regional director appointed by the Secretary;

(2) one deputy director appointed by the regional director to represent the Indian and Alaska Native tribes in the region, if any; and

(3) one deputy direction appointed by the regional director to oversee long-term services and supports.

(c) REGIONAL OFFICE DUTIES.—Each regional director shall—

(1) provide an annual health care needs assessment with respect to the region under the director's jurisdiction to the Secretary after a thorough examination of health needs and in consultation with public health officials, clinicians, patients, and patient advocates;

(2) recommend any changes in provider reimbursement or payment for delivery of health services

determined appropriate by the regional director, subject to the provisions of title VI; and

(3) establish a quality assurance mechanism in each such region in order to minimize both underutilization and overutilization of health care items and services and to ensure that all providers meet quality standards established pursuant to this Act.

SEC. 404. BENEFICIARY OMBUDSMAN.

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

(b) DUTIES.—The Beneficiary Ombudsman shall—

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

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

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

SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.

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

Subtitle B—Control Over Fraud and Abuse

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

The following sections of the Social Security Act shall apply to this Act in the same manner as they apply to

title XVIII or State plans under title XIX of the Social Security Act:

(1) Section 1128 (relating to exclusion of individuals and entities).

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

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

(6) Section 1877 (relating to physician referrals).

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be implemented and evaluated by the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this title as the ''Center'') or such other agency determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

(b) DUTIES OF THE CENTER.—The Center shall perform the following duties:

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

(2) Review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.). In so reviewing and evaluating, the Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of items and services provided by health care institutions or health care professionals. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments. The Center shall consider the evidentiary basis for the standard, and the validity, reliability, and feasibility of measuring the standard.

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

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

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

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accurate, and timely collection of data on disparities in health care services and performance on the basis of race, ethnicity, national origin, primary language use, age, dis-

ability, sex (including gender identity and sexual orientation), geography, or socioeconomic status. In conducting such evaluation, the Center shall consider the following objectives:

(1) Protecting patient privacy.

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

(3) Improving data on race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

(1) REPORT ON EVALUATION.—Not later than 18 months after the date on which benefits first become available as described in section 106(a), the Center shall submit to Congress and the Secretary a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

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

cluding gender identity and sexual orientation), geography, or socioeconomic status under the Medicare for All Program; and

(B) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under subsection (b)(1), and every 4 years thereafter, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 2 years after the date on which benefits first become available as described in section 106(a), the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, na-

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

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

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

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

(A) An operating budget.

(B) A capital expenditures budget.

(C) A special projects budget.

(D) Quality assessment activities under title V.

(E) Health professional education expenditures.

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

(G) A reserve fund.

(H) Prevention and public health activities.

(3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the funds received for purposes of carrying out this Act among the components described in paragraph (2) in a manner that ensures—

(A) that the operating budget allows for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations;

(B) that the special projects budget is sufficient to meet the health care needs within areas described in paragraph (2)(C) through the construction, renovation, and staffing of health care facilities in a reasonable timeframe;

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

(D) that the health professional education expenditure component is sufficient to provide for the amount of health professional education

expenditures sufficient to meet the need for covered health care services.

(4) REGIONAL ALLOCATION.—The Secretary shall annually provide each regional office with an allotment the Secretary determines appropriate for purposes of carrying out this Act in such region, including payments to providers in such region, capital expenditures in such region, special projects in such region, health professional education in such region, administrative expenses in such region, and prevention and public health activities in such region.

(5) OPERATING BUDGET.—The operating budget described in paragraph (2)(A) shall be used for—

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

(B) payments to individual providers pursuant to section 612.

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

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

(B) major equipment purchases.

(7) SPECIAL PROJECTS BUDGET.—The special projects budget described in paragraph (2)(C) shall be used for the purposes of allocating funds for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))), and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

(8) TEMPORARY WORKER ASSISTANCE.—

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

who may be affected by the implementation of this Act and who may experience economic dislocation as a result of the implementation of this Act.

(B) CLARIFICATION.—Assistance described in subparagraph (A) shall include wage replacement, retirement benefits, job training and placement, preferential hiring, and education benefits.

(9) RESERVE FUND.—The reserve fund described in paragraph (2)(G) shall be used to respond to the costs of an epidemic, pandemic, natural disaster, or other such health emergency, or market-shift adjustments related to patient volume.

(10) SUPPLEMENTAL INDIAN HEALTH SERVICE ALLOCATION.—The Secretary shall annually determine the need to provide an allotment of supplemental funds to Indian Health Services, including payments to providers, capital expenditures, special projects, health professional education, administrative expenses, and prevention and public health activities.

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase,

lease, construction, or renovation of capital facilities and for major equipment.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities, including the impact of workforce diversity on patient outcomes.

Subtitle B—Payments to Providers

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

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

(1) PAYMENT IN FULL.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under this Act, whether inpatient or outpatient, by such provider for such quarter, including outpatient or any

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

(2) QUARTERLY REVIEW.—The regional director, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and shall determine whether adjustments to such institutional provider's payment are warranted. This review shall include consideration for additional funding necessary for unanticipated items and services for individuals with complex medical needs or market-shift adjustments related to patient volume. The review shall also include an assessment of any adjustments made to ensure that accuracy and need for adjustment was appropriate.

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

budget in lieu of payment under section 612 of this title. Any—

(A) individual health care professional of such group practice or other provider receiving payment through an institutional provider's global budget shall be paid on a salaried basis that is equivalent to salaries or other compensation rates negotiated for individual health care professionals of such institutional provider; and

(B) any group practice or other health care provider that receives payment through an institutional provider global budget under this paragraph shall be subject to the same reporting and disclosure requirements of the institutional provider.

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

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

(i) natural disasters;

(ii) outbreaks of epidemics or infectious diseases;

(iii) unexpected facility or equipment repairs or purchases;

(iv) significant and unexpected increases in pharmaceutical or medical device prices; and

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

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

(C) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—The amount of each payment to a provider described in subsection (a) shall be determined before the start of each fiscal year through negotiations between the provider and the regional director with jurisdiction over such provider. Such amount shall be based on factors specified in paragraph (2).

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

(A) the historical volume of services provided for each item and services in the previous 3-year period;

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

(i) such expenditures for other institutional providers in the director's jurisdiction; and

(ii) normative payment rates established under comparative payment rate systems, including any adjustments, for such items and services;

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

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

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

(F) education and prevention programs;

(G) permissible adjustment to the provider's operating budget due to factors such as—

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

(ii) efforts to decrease health care disparities in rural or medically underserved areas;

(iii) a response to emergent epidemic conditions;

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

(v) proposed new and innovative patient care programs at the institutional level;

(H) whether the provider is located in a high social vulnerability index community, ZIP Code, or census track, or is a minority-serving provider; and

(I) any other factor determined appropriate by the Secretary.

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

(A) take into account capital expenditures of the provider or any other expenditure not directly associated with the provision of items and services by the provider to an individual;

(B) be used by a provider for capital expenditures or such other expenditures;

(C) exceed the provider's capacity to provide care under this Act; or

(D) be used to pay or otherwise compensate any board member, executive, or administrator of the institutional provider who has any interest or relationship prohibited under section 301(b)(2) of this Act or disclosed under section 301 of this Act.

(4) LIMITATION ON COMPENSATION.—Compensation costs for any employee or any contractor or any subcontractor employee of an institutional provider receiving global budgets under this section shall meet the compensation cap established in section 702 of the Bipartisan Budget Act of 2013 (41 U.S.C. 4304(a)(16)) and implementing regulations.

(5) REGIONAL NEGOTIATIONS PERMITTED.—Subject to section 614, a regional director may nego-

tiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market-shifts related to patient volume.

(c) BASELINE RATES AND ADJUSTMENTS.—

(1) IN GENERAL.—The Secretary shall use existing prospective payment systems under title XVIII of the Social Security Act to serve as the comparative payment rate system in global budget negotiations described in subsection (b). The Secretary shall update such comparative payment rate systems annually.

(2) SPECIFICATIONS.—In developing the comparative payment rate system, the Secretary shall use only the operating base payment rates under each such prospective payment systems with applicable adjustments.

(3) LIMITATION.—The comparative rate system established under this subsection shall not include the value-based payment adjustments and the capital expenses base payment rates that may be included in such a prospective payment system.

(4) INITIAL YEAR.—In the first year that global budget payments under this Act are available to institutional providers and for purposes of selecting a comparative payment rate system used during initial

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

(d) OPERATING EXPENSES.—For purposes of this title, ''operating expenses'' of a provider include the following:

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

(A) Wages and salary costs for physicians, nurses, and other health care practitioners employed by an institutional provider, including mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other healthcare workers.

(B) Wages and salary costs for all ancillary staff and services.

(C) Costs of all pharmaceutical products administered by health care clinicians at the institutional provider's facilities or through services provided in accordance with State licensing laws or regulations under which the institutional provider operates.

(D) Costs for infectious disease response preparedness, including maintenance of a 1-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, medical services for occupational infectious disease exposure, and contact tracing.

(E) Purchasing and maintenance of medical devices, supplies, and other health care technologies, including diagnostic testing equipment.

(F) Costs of all incidental services necessary for safe patient care and handling.

(G) Costs of patient care, education, and prevention programs, including occupational health and safety programs, public health programs, and necessary staff to implement such programs, for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(2) Administrative costs for the institutional provider.

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

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

(b) FEE SCHEDULE.—

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

the fee-for-service structure and update such fee schedule annually.

(2) AMOUNTS.—In establishing payment amounts for items and services under the fee schedule established under paragraph (1), the Secretary shall take into account—

(A) the amounts payable for such items and services under title XVIII of the Social Security Act; and

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

(c) ELECTRONIC BILLING.—The Secretary shall establish a uniform national system for electronic billing for purposes of making payments under this subsection.

(d) PHYSICIAN PRACTICE REVIEW BOARD.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician-delivered items and services. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments.

SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

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

''(P) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—

''(i) IN GENERAL.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall establish, document, and make publicly available, in consultation with the Office of Primary Health Care, a standardized process for reviewing the relative values of physicians' services under this paragraph.

''(ii) MINIMUM REQUIREMENTS.—The standardized process shall include, at a minimum, methods and criteria for identifying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying additional resources to be considered during the review process.''.

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

"(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.".

(c) INTERNAL TRACKING OF REVIEWS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a proposed plan for systematically and internally tracking the Secretary's review of the relative values of physicians' services, such as by establishing an internal database, under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by this section.

(2) MINIMUM REQUIREMENTS.—The proposal shall include, at a minimum, plans and a timeline

for achieving the ability to systematically and internally track the following:

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

(B) When services are reviewed or reviewed or when new services are added.

(C) The resources, evidence, data, and recommendations used in reviews.

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

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

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

(2) in subparagraph (K)(i)(I), by striking ''periodically'' and inserting ''annually''.

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

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

(A) in subparagraph (B)(i), by inserting ''in consultation with the Medicare Payment

Advisory Commission,'' after ''The Secretary,'';
and

(B) in subparagraph (K)(i)(I), as amended by subsection (d)(2), by inserting '', in coordination with the Medicare Payment Advisory Commission,'' after ''annually''.

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

(A) in subsection (b)(1)(A), by inserting the following before the semicolon at the end: ''and including coordinating with the Secretary in accordance with section 1848(c)(2) to systematically review the relative values established for physicians' services, identify potentially misvalued services, and propose adjustments to the relative values for physicians' services''; and

(B) in subsection (e)(1), in the second sentence, by inserting ''or the Ranking Minority Member'' after ''the Chairman''.

(f) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(Q) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—

''(i) IN GENERAL.—The Comptroller General of the United States (in this subsection referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

''(ii) ACCESS TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data related to the activities carried out under this paragraph, in a timely manner, upon request.''.

SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDITURES; SPECIAL PROJECTS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that tens of millions of people in the United States do not receive healthcare services while billions of dollars that could be spent on providing health care are diverted to profit. There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of health care.

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

(1) marketing of the provider;

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

(3) incentive payments, bonuses, or other compensation based on patient utilization of items and services or any financial measure applied with respect to the provider (or any group practice, integrated health care delivery system, or other provider with which the provider contracts or has a pecuniary interest), including any value-based payment or employment-based compensation;

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

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

(c) PAYMENTS FOR CAPITAL EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall pay, from amounts made available for capital expendi-

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

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

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

and changes in emergency room or primary care services or availability.

(4) CAPITAL ASSETS NOT FUNDED BY THE MEDICARE FOR ALL PROGRAM.—Operating expenses and funds shall not be used by an institutional provider receiving payment for capital expenditures under this subsection for a capital asset that was not funded by the Medicare for All program without the approval of the regional director or directors of the region or regions where the capital asset is located.

(d) PROHIBITION AGAINST CO-MINGLING OPERATING AND CAPITAL FUNDS.—Providers that receive payment under this title shall be prohibited from using, with respect to funds made available under this Act—

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

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

(e) PAYMENTS FOR SPECIAL PROJECTS.—

(1) IN GENERAL.—The Secretary shall allocate to each regional director, from amounts made available for special projects pursuant to section 601(a)(2)(C), such sums determined appropriate by the Secretary for purposes of funding projects de-

scribed in such section, including the construction, renovation, or staffing of health care facilities, in rural, underserved, or health professional or medical shortage areas within such region and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, or socioeconomic health disparities. Each regional director shall, prior to distributing such funds in accordance with paragraph (2), present a budget describing how such funds will be distributed to the Secretary.

(2) DISTRIBUTION.—A regional director shall distribute funds to providers operating in the region of such director's jurisdiction in a manner determined appropriate by the director.

(f) PROHIBITION ON FINANCIAL INCENTIVE METRICS IN PAYMENT DETERMINATIONS.—The Secretary may not utilize any quality metrics or standards for the purposes of establishing provider payment methodologies, programs, modifiers, or adjustments for provider payments under this title.

SEC. 615. OFFICE OF HEALTH EQUITY.

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

"SEC. 1712. OFFICE OF HEALTH EQUITY.

''(a) IN GENERAL.—There is established, in the Office of the Secretary of Health and Human Services, an Office of Health Equity, to be headed by a Director, to ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to ensuring health equity.

''(b) MONITORING, TRACKING, AND AVAILABILITY OF DATA.—

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

''(A) the disproportionate burden of disease and death among people of color, disaggregated by race, major ethnic group, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status;

''(B) barriers to health, including such barriers relating to income, education, housing, food insecurity (including availability, access, utilization, and stability), employment status, working conditions, and conditions related to the physical environment (including pollutants and population density);

''(C) barriers to health care access, including—

''(i) lack of trust and awareness;

''(ii) lack of transportation;

''(iii) geography;

''(iv) hospital and service closures;

''(v) lack of health care infrastructure and facilities; and

''(vi) lack of health care professional staffing and recruitment;

''(D) disparities in quality of care received, including discrimination in health care settings and the use of racially-biased practice guidelines and algorithms; and

''(E) disparities in utilization of care.

''(2) ANALYSIS OF CROSS-SECTIONAL INFORMATION.—The Director of the Office of Health Equity shall ensure that the data collection and reporting

process under paragraph (1) allows for the analysis of cross-sectional information on people's identities.

''(c) POLICIES.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop, coordinate, and promote policies that enhance health equity, including by—

''(1) providing recommendations on—

''(A) cultural competence, implicit bias, and ethics training with respect to health care workers;

''(B) increasing diversity in the health care workforce; and

''(C) ensuring sufficient health care professionals and facilities; and

''(2) ensuring adequate public health funding at the local and State levels to address health disparities.

''(d) CONSULTATION.—In carrying out subsection (a), the Director of the Office of Health Equity, in coordination with the Director of the Indian Health Service, shall consult with Indian Tribes and with Urban Indian organizations on data collection, reporting, and implementation of policies.

''(e) ANNUAL REPORT.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop and publish an annual report on—

''(1) statistics collected by the Office;

''(2) proposed evidence-based solutions to mitigate health inequities; and

''(3) health care professional staffing levels and access to facilities.

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

''(1) establish and maintain a centralized electronic repository to incorporate data collected across Federal departments and agencies on race, ethnicity, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status; and

''(2) make such data available for public use and analysis.

''(g) PRIVACY.—Notwithstanding any other Federal or State law, no Federal or State official or employee or other entity shall disclose, or use, for any law enforcement

or immigration purpose, any personally identifiable information (including with respect to an individual's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status) that is collected or maintained pursuant to this section.''.

SEC. 616. OFFICE OF PRIMARY CARE.

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

''SEC. 1713. OFFICE OF PRIMARY CARE.

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

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

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

''(2) to address health disparities, including with respect to race, ethnicity, national origin (disaggregated by major ethnic group and Tribal affiliation), primary language use, English proficiency status, immigration status, length of stay in the United States, age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status.

''(c) OTHER RESPONSIBILITIES.—In carrying out subsections (a) and (b), the Director of the Office of Primary Health Care shall—

''(1) coordinate, in consultation with the Secretary, health professional education policies and goals to achieve the national goals published pursuant to subsection (b);

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

''(3) develop, coordinate, and promote policies that expand the number of primary health care practitioners, registered nurses, advance practice clinicians, and dentists;

''(4) recommend appropriate training, technical assistance, and patient protection enhancements for primary care health professionals, including registered nurses, to achieve uniform high quality and patient safety;

''(5) provide recommendations on targeted programs and resources for Federally qualified health centers, rural health centers, community health centers, and other community-based organizations;

''(6) provide recommendations for broader patient referral to additional resources, not limited to health care, and collaboration with other organizations and sectors that influence health outcomes; and

''(7) consult with the Secretary on the allocation of the special projects budget under section 601(a)(2)(C) of the Medicare for All Act.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to preempt any provision of State law establishing practice standards or guidelines for health care professionals, including professional licensing or practice laws or regulations; or

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

SEC. 617. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.

The prices to be paid for covered pharmaceuticals, medical supplies, medical technologies, and medically necessary equipment covered under this Act shall be negotiated annually by the Secretary.

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, for fiscal years beginning on or after the date of the enactment of this subsection, negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to the Medicare for All Program during a negotiated price period (as specified by the Secretary) for covered drugs for eligible individuals under the Medicare for All Program. In negotiating such prices under this section, the Secretary shall take into account the following factors:

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

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

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

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

(2) FINALIZATION OF NEGOTIATED PRICE.—The negotiated price of each covered drug for a negotiated price period shall be finalized not later than 30 days before the first fiscal year in such negotiated price period.

(3) COMPETITIVE LICENSING AUTHORITY.—

(A) IN GENERAL.—Notwithstanding any exclusivity under clause (iii) or (iv) of section 505(j)(5)(F) of the Federal Food, Drug, and Cosmetic Act, clause (iii) or (iv) of section 505(c)(3)(E) of such Act, section 351(k)(7)(A) of the Public Health Service Act, or section 527(a) of the Federal Food, Drug, and Cosmetic Act, or by an extension of such exclusivity under section 505A of such Act or section 505E of such Act, and any other provision of law that

provides for market exclusivity (or extension of market exclusivity) with respect to a drug, in the case that the Secretary is unable to success fully negotiate an appropriate price for a covered drug for a negotiated price period, the Secretary shall authorize the use of any patent, clinical trial data, or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under Medicare for All Program. Any entity making use of a competitive license to use patent, clinical trial data, or other exclusivity under this section shall provide to the manufacturer holding such exclusivity reasonable compensation, as determined by the Secretary based on the following factors:

(i) The risk-adjusted value of any Federal Government subsidies and investments in research and development used to support the development of such drug.

(ii) The risk-adjusted value of any investment made by such manufacturer in the research and development of such drug.

(iii) The impact of the price, including license compensation payments, on meeting the medical need of all patients at a reasonable cost.

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

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

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

(C) INTERIM PERIOD.—Until 1 year after a drug described in subparagraph (A) is approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act or section 351(k) of the Public Health Service Act and is provided under license issued by the Secretary under such subparagraph, the Medicare for All Program shall not pay more for such drug than the average of the prices available, during the most recent 12-month period for which data is

available prior to the beginning of such negotiated price period, from the manufacturer to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity in the ten OECD (Organization for Economic Cooperation and Development) countries that have the largest gross domestic product with a per capita income that is not less than half the per capita income of the United States.

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

(4) FDA REVIEW OF LICENSED DRUG APPLICATIONS.—The Secretary shall prioritize review of applications under section 505(j) of the Federal Food, Drug, and Cosmetic Act for drugs licensed under paragraph (3)(A).

(5) PROHIBITION OF ANTICOMPETITIVE BEHAVIOR.—No drug manufacturer may engage in anticompetitive behavior with another manufacturer that may interfere with the issuance and implementation

of a competitive license or run contrary to public policy.

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

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

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

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits first become available as described in section 106, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is at-

tributable to the amendments made by sections 801 and 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—

(A) INITIAL YEAR.—Notwithstanding any other provision of law, there is appropriated to the Trust Fund for the fiscal year containing January 1 of the first year following the date of the enactment of this Act, an amount equal to the aggregate amount appropriated for the preceding fiscal year for the following (increased by the consumer price index for all urban consumers for the fiscal year involved):

(i) The Medicare program under title XVIII of the Social Security Act (other

than amounts attributable to any premiums under such title).

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

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

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

(v) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health

services the payment of which may be made under this Act.

(B) SUBSEQUENT YEARS.—Notwithstanding any other provision of law, there is appropriated to the trust fund for the fiscal year containing January 1 of the second year following the date of the enactment of this Act, and for each fiscal year thereafter, an amount equal to the amount appropriated to the Trust Fund for the previous year, adjusted for reductions in costs resulting from the implementation of this Act, changes in the consumer price index for all urban consumers for the fiscal year involved, and other factors determined appropriate by the Secretary.

(3) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act (42 U.S.C. 1395i) shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust

Fund under such section 1817, except that, for purposes of applying such subsections to this section, the ''Board of Trustees of the Trust Fund'' shall mean the ''Secretary''.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) after the payment of claims for items and services furnished under title XVIII of such Act have been completed, shall be transferred into the Universal Medicare Trust Fund under this section.

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.

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

"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF UNIVERSAL MEDICARE PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

''(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act.

''(b) REIMBURSEMENT.—Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the Medicare for All Program for the cost of such services.

''(c) DEFINITIONS.—In this subsection—

''(1) the term 'workers compensation carrier' means an insurance company that underwrite workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits;

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

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

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of the Medicare for All Program by workers compensation carriers).''.

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

''Sec. 522. Prohibition of employee benefits duplicative of Universal Medicare Program benefits; coordination in case of workers' compensation.''.

SEC. 802. APPLICATION OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

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

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

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

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

SEC. 803. EFFECTIVE DATE OF TITLE.

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

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

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

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished on or after such date;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act for any item or service furnished on or after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the effective date of benefits under section 106, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI of such Act, the Secretary shall provide for continu-

ation of benefits under such title or plan until the end of the period of stay.

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

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

(c) TRICARE PROGRAM.—

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

(2) PURCHASED CARE COMPONENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no benefits shall be made available under the purchased care component of the TRICARE program for items or services

furnished to any individual eligible to enroll under this Act.

(B) TRICARE OVERSEAS.—During any period in which an individual is eligible for benefits under the TRICARE Overseas Program and is located in a TRICARE overseas region, the individual may receive benefits for items or services furnished to the individual under the purchased care component of such program during such period.

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

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

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

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

Effective on the date that is 2 years after the date of the enactment of this Act, the Federal and State Ex-

changes established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

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

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

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

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

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

ant to subsection (o) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(o));

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

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

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

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

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

(D) Section 3002(b) (42 U.S.C. 1395w–4(a)(8)) (incentive payments for quality reporting).

(E) Section 3001(a) (42 U.S.C. 1395ww(o)) (Hospital Value-Based Purchasing).

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

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

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

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

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

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

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

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

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO YEARS.

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

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

''(a) TRANSITION.—

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

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

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

''(A) The individual meets the eligibility requirements established by the Secretary under title I of the Medicare for All Act.

''(B) The individual has attained the applicable year of age, or is currently enrolled in Medicare at the time of the transition to Medicare for All.

''(4) APPLICABLE YEAR OF AGE DEFINED.—For purposes of this section, the term 'applicable year of age' means one year after the date of enactment of the Medicare for All Act, the age of 55 or older, the age 18 or younger.

''(b) ENROLLMENT; COVERAGE.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

''(c) SATISFACTION OF INDIVIDUAL MANDATE.—For purposes of applying section 5000A of the Internal Revenue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

''(d) CONSULTATION.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing beneficiaries, health care providers, employers, and insurance companies.''.

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION BUY-IN.

(a) IN GENERAL.—To carry out the purpose of this section, for the year beginning one year after the date of enactment of this Act and ending with the effective date described in section 106(a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the ''Administrator''), shall establish, and provide for the offering through the Exchanges, an option to buy in to the Medicare for All Program (in this Act referred to as the ''Medicare Transition buy-in'').

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

(1) ADMINISTRATOR.—The Administrator shall administer the Medicare Transition buy-in in accordance with this section.

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

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

(3) OFFERING THROUGH EXCHANGES.—The Medicare Transition buy-in shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032)) who wish to make such plan available to their employees.

(4) ELIGIBILITY TO PURCHASE.—Any United States resident may enroll in the Medicare Transition buy-in.

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

(1) coverage for the benefits required to be covered under title II of this Act; and

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

(d) PROVIDERS AND REIMBURSEMENT RATES.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition buy-in, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the Medicare for All fee-for-service schedule established in section 612(b) of this Act.

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

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this Act shall be a participating provider in the Medicare Transition buy-in.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow

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

(e) PREMIUMS.—

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

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

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

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

of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

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

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

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION BUY-IN ENROLLEES IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULES FOR MEDICARE TRANSITION BUY-IN ENROLLEES.—

"(i) IN GENERAL.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act for all months in the taxable year, subparagraph (A) shall be

applied without regard to 'but does not exceed 400 percent'.

''(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for All Act) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.''.

(B) PREMIUM ASSISTANCE AMOUNTS FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—

(i) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of such Code is

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

''(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu 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.''.

(ii) CONFORMING AMENDMENT.—Subclause (I) of clause (iii) of section 36B(b)(3) of such Code, as redesignated

by subparagraph (A)(i), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(2) COST-SHARING SUBSIDIES.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(A) by inserting ", or in the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act," after "coverage" in paragraph (1);

(B) by redesignating paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(C) by striking "INSURED.—In this section" and inserting "INSURED.—

"(1) IN GENERAL.—In this section";

(D) by striking the flush language; and

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

"(2) SPECIAL RULES.—

"(A) INDIVIDUALS LAWFULLY PRESENT.—In the case of an individual described in section

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

''(B) MEDICARE TRANSITION BUY-IN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition buy-in, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.''.

(h) CONFORMING AMENDMENTS.—

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

(A) in the paragraph heading, by inserting ''THE MEDICARE TRANSITION BUY-IN,'' before ''AND''; and

(B) by inserting ''The Medicare Transition buy-in,'' before ''and a multi-State plan''.

(2) LEVEL PLAYING FIELD.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting ''the Medicare Transition buy-in,'' before ''or a multi-State qualified health plan''.

Subtitle B—Transitional Medicare Reforms

SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

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

(2) in paragraph (2)(B), by striking '', and has been for not less than 24 months,'';

(3) in paragraph (2)(C)(ii), by striking '', including the requirement that he has been entitled to the specified benefits for 24 months,'';

(4) in the first sentence, by striking ''for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and'' and inserting ''for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and''; and

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

(b) CONFORMING AMENDMENTS.—

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

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

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

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

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''25th month of'' and inserting ''month following the first month of''.

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

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking '', for not less than 24 months''; and

(C) by striking ''could have been entitled for 24 calendar months, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before the date that is 2 years after the date of the enactment of such Act.

SEC. 1012. ENSURING CONTINUITY OF CARE.

(a) IN GENERAL.—The Secretary shall ensure that all persons enrolled or who seeks to enroll in a health plan during the transition period of the Medicare for All Pro-

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

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

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

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

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

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

condition during the transition period described in the Act until all ages are eligible to enroll in the Medicare for All Program; or

(B) impose any exclusion with respect to such plan or coverage on the basis of a person's disability, complex medical need, or chronic condition during the transition period described under this Act until all ages are eligible to enroll in the Medicare for All Program.

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

TITLE XI—MISCELLANEOUS

SEC. 1101. DEFINITIONS.

In this Act—

(1) the term ''global budget'' means the payment negotiated between an institutional provider and as described in section 611(b);

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

(3) the term ''individual provider'' means a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)));

(4) the term ''institutional provider'' means—

(A) providers of services described in section 1861(u) of such Act (42 U.S.C. 1395x(u));

(B) hospitals as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), and any outpatient settings or clinics operating within a hospital license or any setting or clinic that provides outpatient hospital services;

(C) psychiatric hospitals (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(f)));

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

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

(F) independent dialysis facilities and independent end-stage renal disease facilities as described in 42 CFR 413.174(b);

(5) the term ''medically necessary or appropriate'' means the health care items and services or supplies that are needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms for an individual and are determined to be necessary or appropriate for such individual by the physician or other health care professional treating such individual, after such professional performs an assessment of such individual's condition, in a manner that meets—

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

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

(6) the term ''provider'' means an institutional provider or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) if the reference to ''this title'' were a reference to the Medicare for All Program);

(7) the term ''Secretary'' means the Secretary of Health and Human Services;

(8) the term ''State'' means a State, the District of Columbia, or a territory of the United States;

(9) the term ''TRICARE Overseas Program'' means the element of the TRICARE program administered by International SOS (or such successor administrator) under which care and health benefits are furnished to TRICARE beneficiaries located in a TRICARE overseas region;

(10) the term ''TRICARE program'' has the meaning given such term in section 1072 of title 10, United States Code;

(11) the term ''uniformed services'' has the meaning given such term in section 101 of title 10, United States Code; and

(12) the term ''United States'' shall include the States, the District of Columbia, and the territories of the United States.

SEC. 1102. RULES OF CONSTRUCTION.

(a) IN GENERAL.—A State or local government may set additional standards or apply other State or local laws with respect to eligibility, benefits, and minimum provider standards, only if such State or local standards—

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

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

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

(4) allow for the effective exercise of the professional judgment of physicians or other health care professionals; and

(5) are otherwise consistent with this Act.

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

(c) APPLICATION TO STATE AND FEDERAL LAW ON WORKPLACE RIGHTS.—Nothing in this Act shall be construed to diminish or alter the rights, privileges, remedies, or obligations of any employee or employer under any Federal or State law or regulation or under any collective bargaining agreement.

(d) RESTRICTIONS ON PROVIDERS.—With respect to any individuals or entities certified to provide items and services covered under section 201(a)(7), a State may not prohibit an individual or entity from participating in the

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

SEC. 1103. NO USE OF RESOURCES FOR LAW ENFORCEMENT OF CERTAIN REGISTRATION REQUIREMENTS.

Notwithstanding any provision of Federal or State law, no Federal or State law enforcement official or employee shall use any funds, facilities, property, equipment, or personnel made available pursuant to this Act (or any amendment made thereby) to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the Federal Government based on religion, national origin, ethnicity, immigration status, or other protected category.