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(Original Signature of Member)

116TH 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.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare for All Act of 2019”.

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

Sec. 1. Short title; table of contents.

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

- Sec. 101. Establishment of the Medicare for All Program.
- Sec. 102. Universal coverage.
- Sec. 103. Freedom of choice.
- Sec. 104. Non-discrimination.
- Sec. 105. Enrollment.
- Sec. 106. Effective date of benefits.
- Sec. 107. Prohibition against duplicating coverage.

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

- Sec. 201. Comprehensive benefits.
- Sec. 202. No cost-sharing.
- Sec. 203. Exclusions and limitations.
- Sec. 204. Coverage of long-term care services.

TITLE III—PROVIDER PARTICIPATION

- Sec. 301. Provider participation and standards; whistleblower protections.
- Sec. 302. Qualifications for providers.
- Sec. 303. Use of private contracts.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

- Sec. 401. Administration.
- Sec. 402. Consultation.
- Sec. 403. Regional administration.
- Sec. 404. Beneficiary ombudsman.
- Sec. 405. Conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

- Sec. 411. Application of Federal sanctions to all fraud and abuse under the Medicare for All Program.

TITLE V—QUALITY ASSESSMENT

- Sec. 501. Quality standards.
- Sec. 502. Addressing health care disparities.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT
MEASURES

Subtitle A—Budgeting

- Sec. 601. National health budget.

Subtitle B—Payments to Providers

- Sec. 611. Payments to institutional providers based on global budgets.
- Sec. 612. Payment to individual providers through fee-for-service.
- Sec. 613. Ensuring accurate valuation of services under the Medicare physician fee schedule.
- Sec. 614. Payment prohibitions; capital expenditures; special projects.
- Sec. 615. Office of primary health care.
- Sec. 616. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Sec. 701. Universal Medicare Trust Fund.

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

Sec. 801. Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers' compensation.

Sec. 802. Application of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.

Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

Sec. 901. Relationship to existing Federal health programs.

Sec. 902. Sunset of provisions related to the State Exchanges.

Sec. 903. Sunset of provisions related to pay for performance programs.

TITLE X—TRANSITION

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

Sec. 1001. Medicare for all transition over two years.

Sec. 1002. Establishment of the Medicare transition buy-in.

Subtitle B—Transitional Medicare Reforms

Sec. 1011. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.

Sec. 1012. Ensuring continuity of care.

TITLE XI—MISCELLANEOUS

Sec. 1101. Definitions.

Sec. 1102. Rules of construction.

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

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

7 There is hereby established a national health insur-
8 ance program to provide comprehensive protection against
9 the costs of health care and health-related services, in ac-

1 cordance with the standards specified in, or established
2 under, this Act.

3 **SEC. 102. UNIVERSAL COVERAGE.**

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

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

19 **SEC. 103. FREEDOM OF CHOICE.**

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

23 **SEC. 104. NON-DISCRIMINATION.**

24 (a) IN GENERAL.—No person shall, on the basis of
25 race, color, national origin, age, disability, marital status,

1 citizenship status, primary language use, genetic condi-
2 tions, previous or existing medical conditions, religion, or
3 sex, including sex stereotyping, gender identity, sexual ori-
4 entation, and pregnancy and related medical conditions
5 (including termination of pregnancy), be excluded from
6 participation in or be denied the benefits of the program
7 established under this Act (except as expressly authorized
8 by this Act for purposes of enforcing eligibility standards
9 described in section 102), or be subject to any reduction
10 of benefits or other discrimination by any participating
11 provider (as defined in section 301), or any entity con-
12 ducting, administering, or funding a health program or
13 activity, including contracts of insurance, pursuant to this
14 Act.

15 (b) CLAIMS OF DISCRIMINATION.—

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

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

1 (3) DAMAGES.—If the court finds a violation of
2 subsection (a), the court may grant compensatory
3 and punitive damages, declaratory relief, injunctive
4 relief, attorneys’ fees and costs, or other relief as ap-
5 propriate.

6 (c) CONTINUED APPLICATION OF LAWS.—Nothing in
7 this title (or an amendment made by this title) shall be
8 construed to invalidate or otherwise limit any of the rights,
9 remedies, procedures, or legal standards available to indi-
10 viduals aggrieved under section 1557 of the Patient Pro-
11 tection and Affordable Care Act (42 U.S.C. 18116), title
12 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et
13 seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.
14 2000e et seq.), title IX of the Education Amendments of
15 1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-
16 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-
17 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing
18 in this title (or an amendment to this title) shall be con-
19 strued to supersede State laws that provide additional pro-
20 tections against discrimination on any basis described in
21 subsection (a).

22 **SEC. 105. ENROLLMENT.**

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

1 (1) include a process for the automatic enroll-
2 ment of individuals at the time of birth in the
3 United States (or upon establishment of residency in
4 the United States);

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

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

12 (b) **ISSUANCE OF UNIVERSAL MEDICARE CARDS.**—
13 In conjunction with an individual's enrollment for benefits
14 under this Act, the Secretary shall provide for the issuance
15 of a Universal Medicare card that shall be used for pur-
16 poses of identification and processing of claims for bene-
17 fits under this program. The card shall not include an in-
18 dividual's Social Security number.

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

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

24 (b) **COVERAGE FOR CERTAIN INDIVIDUALS.**—

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

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

6 (B) has attained the age of 55 as of the
7 date that is 1 year after the date of the enact-
8 ment of this Act;

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

11 (2) OPTION TO CONTINUE IN OTHER COVERAGE
12 DURING TRANSITION PERIOD.—Any person who is
13 eligible to receive benefits as described in paragraph
14 (1) may opt to maintain any coverage described in
15 section 901, private health insurance coverage, or
16 coverage offered pursuant to subtitle A of title X
17 (including the amendments made by such subtitle)
18 until the date described in subsection (a).

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

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

22 (1) a private health insurer to sell health insur-
23 ance coverage that duplicates the benefits provided
24 under this Act; or

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

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

11 **TITLE II—COMPREHENSIVE BEN-**
12 **EFITS, INCLUDING PREVEN-**
13 **TIVE BENEFITS AND BENE-**
14 **FITS FOR LONG-TERM CARE**

15 **SEC. 201. COMPREHENSIVE BENEFITS.**

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

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

- 1 (2) Ambulatory patient services.
- 2 (3) Primary and preventive services, including
3 chronic disease management.
- 4 (4) Prescription drugs and medical devices, in-
5 cluding outpatient prescription drugs, medical de-
6 vices, and biological products.
- 7 (5) Mental health and substance abuse treat-
8 ment services, including inpatient care.
- 9 (6) Laboratory and diagnostic services.
- 10 (7) Comprehensive reproductive, maternity, and
11 newborn care.
- 12 (8) Pediatrics.
- 13 (9) Oral health, audiology, and vision services.
- 14 (10) Rehabilitative and habilitative services and
15 devices.
- 16 (11) Emergency services and transportation.
- 17 (12) Early and periodic screening, diagnostic,
18 and treatment services, as described in sections
19 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B),
20 1905(r) of the Social Security Act (42 U.S.C.
21 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B);
22 1396d(r)).
- 23 (13) Necessary transportation to receive health
24 care services for persons with disabilities or low-in-
25 come individuals (as determined by the Secretary).

1 (14) Long-term care services and support (as
2 described in section 204).

3 (b) REVISION AND ADJUSTMENT.—The Secretary
4 shall, at least annually, and on a regular basis, evaluate
5 whether the benefits package should be improved or ad-
6 justed to promote the health of beneficiaries, account for
7 changes in medical practice or new information from med-
8 ical research, or respond to other relevant developments
9 in health science, and shall make recommendations to
10 Congress regarding any such improvements or adjust-
11 ments.

12 (c) HEARINGS.—

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

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

21 (A) as an exercise of rulemaking power of
22 the House of Representatives, and, as such,
23 shall be considered as part of the rules of the
24 House, and such rules shall supersede any other

1 rule of the House only to the extent that rule
2 is inconsistent therewith; and

3 (B) with full recognition of the constitu-
4 tional right of either House to change such
5 rules (so far as relating to the procedure in
6 such House) at any time, in the same manner,
7 and to the same extent as in the case of any
8 other rule of the House.

9 (d) COMPLEMENTARY AND INTEGRATIVE MEDI-
10 CINE.—

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

14 (A) identifying specific complementary and
15 integrative medicine practices that are appro-
16 priate to include in the benefits package; and

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

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

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

25 (B) the Commissioner of Food and Drugs;

1 (C) institutions of higher education, pri-
2 vate research institutes, and individual re-
3 searchers with extensive experience in com-
4 plementary and alternative medicine and the in-
5 tegration of such practices into the delivery of
6 health care;

7 (D) nationally recognized providers of com-
8 plementary and integrative medicine; and

9 (E) such other officials, entities, and indi-
10 viduals with expertise on complementary and
11 integrative medicine as the Secretary deter-
12 mines appropriate.

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

19 **SEC. 202. NO COST-SHARING.**

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

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

4 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

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

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

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

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

24 (c) APPLICATION OF PRACTICE GUIDELINES.—

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

12 (A) exercised appropriate professional
13 judgment in accordance with the laws and re-
14 quirements of the State in which such item or
15 service is furnished in deviating from the guide-
16 line;

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

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

21 (2) OVERRIDE OF STANDARDS.—

22 (A) IN GENERAL.—An individual's treating
23 physician or other health care professional au-
24 thorized to exercise independent professional
25 judgment in implementing a patient's medical

1 or nursing care plan in accordance with the
2 scope of practice, licensure, and other law of
3 the State where items and services are to be
4 furnished may override practice standards es-
5 tablished pursuant to section 201(a) or practice
6 guidelines described in paragraph (1), including
7 such standards and guidelines that are imple-
8 mented by a provider through the use of health
9 information technology, such as electronic
10 health record technology, clinical decision sup-
11 port technology, and computerized order entry
12 programs.

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

17 (i) consistent with such physician’s,
18 nurse’s, or health care professional’s deter-
19 mination of medical necessity and appro-
20 priateness or nursing assessment;

21 (ii) in the best interests of the indi-
22 vidual; and

23 (iii) consistent with the individual’s
24 wishes.

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

2 (a) IN GENERAL.—Subject to the other provisions of
3 this Act, individuals enrolled for benefits under this Act
4 are entitled to the following long-term services and sup-
5 ports and to have payment made by the Secretary to an
6 eligible provider for such services and supports if medically
7 necessary and appropriate and in accordance with the
8 standards established in this Act, for maintenance of
9 health or for care, services, diagnosis, treatment, or reha-
10 bilitation that is related to a medically determinable condi-
11 tion, whether physical or mental, of health, injury, or age
12 that—

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

15 (2) requires a similar need of assistance in per-
16 forming instrumental activities of daily living due to
17 cognitive or other impairments.

18 (b) ELIGIBILITY.—The Secretary shall promulgate
19 rules that provide for the following:

20 (1) The determination of individual eligibility
21 for long term services and supports under this sec-
22 tion.

23 (2) The assessment of the long-term services
24 and supports needed for eligible individuals.

25 (c) SERVICES AND SUPPORTS.—Long-term services
26 and supports under this section shall be tailored to an in-

1 individual's needs, as determined through assessment, and
2 shall be defined by the Secretary to—

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

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

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

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

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

23 (6) be provided with the goal of enabling per-
24 sons with disabilities to receive services in the least

1 restrictive and most integrated setting appropriate
2 to the individual's needs;

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

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

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

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

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

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

22 (3) groups that represent the diversity of the
23 population of people living with disabilities, including
24 gender, racial, and economic diversity;

1 (4) providers of long-term services and sup-
2 ports, including family attendants and family care-
3 givers, and members of organized labor;

4 (5) disability rights organizations; and

5 (6) relevant academic institutions and research-
6 ers.

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

11 (f) DEFINITIONS.—In this section:

12 (1) The term “long-term services and supports”
13 means long-term care, treatment, maintenance, or
14 services needed to support the activities of daily liv-
15 ing and instrumental activities of daily living, includ-
16 ing all long-term services and supports available
17 under section 1915 of the Social Security Act (42
18 U.S.C. 1396n), home and community-based services,
19 and any additional services and supports identified
20 by the Secretary to support people with disabilities
21 to live, work, and participate in their communities.

22 (2) The term “activities of daily living” means
23 basic personal everyday activities, including tasks
24 such as eating, toileting, grooming, dressing, bath-
25 ing, and transferring.

1 (3) The term “instrumental activities of daily
2 living” means activities related to living independ-
3 ently in the community, including but not limited to,
4 meal planning and preparation, managing finances,
5 shopping for food, clothing, and other essential
6 items, performing essential household chores, com-
7 municating by phone or other media, and traveling
8 around and participating in the community.

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

18 **TITLE III—PROVIDER** 19 **PARTICIPATION**

20 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS;** 21 **WHISTLEBLOWER PROTECTIONS.**

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

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

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

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

10 (b) REQUIREMENTS IN PARTICIPATION AGREE-
11 MENT.—

12 (1) IN GENERAL.—A participation agreement
13 described in this subsection between the Secretary
14 and a provider shall provide at least for the fol-
15 lowing:

16 (A) Items and services to eligible persons
17 shall be furnished by the provider without dis-
18 crimination, in accordance with section 104(a).
19 Nothing in this subparagraph shall be con-
20 strued as requiring the provision of a type or
21 class of items or services that are outside the
22 scope of the provider's normal practice.

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

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

6 (i) quality review by designated enti-
7 ties;

8 (ii) making payments under this Act,
9 including the examination of records as
10 may be necessary for the verification of in-
11 formation on which such payments are
12 based;

13 (iii) statistical or other studies re-
14 quired for the implementation of this Act;
15 and

16 (iv) such other purposes as the Sec-
17 retary may specify.

18 (D) In the case of a provider that is not
19 an individual, the provider agrees not to employ
20 or use for the provision of health services any
21 individual or other provider that has had a par-
22 ticipation agreement under this subsection ter-
23 minated for cause. The Secretary may authorize
24 such employment or use on a case-by-case
25 basis.

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

8 (F) In the case of an institutional provider
9 paid pursuant to section 611, the provider
10 agrees to submit information and any other re-
11 quired supporting documentation as may be
12 reasonably required by the Secretary within 30
13 days after the date of providing such items and
14 services and in accordance with the uniform re-
15 porting standards established under 401(b)(1),
16 including information on a quarterly basis
17 that—

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

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

22 (G) In the case of a provider that receives
23 payment for items and services furnished under
24 this Act based on diagnosis-related coding, pro-

1 cedure coding, or other coding system or data,
2 the provider agrees—

3 (i) to disclose to the Secretary any
4 system or index of coding or classifying pa-
5 tient symptoms, diagnoses, clinical inter-
6 ventions, episodes, or procedures that such
7 provider utilizes for global budget negotia-
8 tions under Title VI or for meeting any
9 other payment, documentation, or data col-
10 lection requirements under this Act; and

11 (ii) not to use any such system or
12 index to establish financial incentives or
13 disincentives for health care professionals,
14 or that is proprietary, interferes with the
15 medical or nursing process, or is designed
16 to increase the amount or number of pay-
17 ments.

18 (H) The provider complies with the duty of
19 provider ethics and reporting requirements de-
20 scribed in paragraph (2).

21 (I) In the case of a provider that is not an
22 individual, the provider agrees that no board
23 member, executive, or administrator of such
24 provider receives compensation from, owns
25 stock or has other financial investments in, or

1 serves as a board member of any entity that
2 contracts with or provides items or services, in-
3 cluding pharmaceutical products and medical
4 devices or equipment, to such provider.

5 (2) PROVIDER DUTY OF ETHICS.—Each health
6 care provider, including institutional providers, has a
7 duty to advocate for and to act in the exclusive in-
8 terest of each individual under the care of such pro-
9 vider according to the applicable legal standard of
10 care, such that no financial interest or relationship
11 impairs any health care provider’s ability to furnish
12 necessary and appropriate care to such individual.
13 To implement the duty established in this para-
14 graph, the Secretary shall—

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

18 (B) prohibit participating providers,
19 spouses, and immediate family members of par-
20 ticipating providers, from accepting or entering
21 into any arrangement for any bonus, incentive
22 payment, profit-sharing, or compensation based
23 on patient utilization or based on financial out-
24 comes of any other provider or entity; and

1 (C) prohibit participating providers or any
2 board member or representative of such pro-
3 vider from serving as board members for or re-
4 ceiving any compensation, stock, or other finan-
5 cial investment in an entity that contracts with
6 or provides items or services (including pharma-
7 ceutical products and medical devices or equip-
8 ment) to such provider.

9 (3) TERMINATION OF PARTICIPATION AGREE-
10 MENT.—

11 (A) IN GENERAL.—Participation agree-
12 ments may be terminated, with appropriate no-
13 tice—

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

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

18 (iii) by a provider.

19 (B) TERMINATION PROCESS.—Providers
20 shall be provided notice and a reasonable oppor-
21 tunity to correct deficiencies before the Sec-
22 retary terminates an agreement unless a more
23 immediate termination is required for public
24 safety or similar reasons.

25 (C) PROVIDER PROTECTIONS.—

1 (i) PROHIBITION.—The Secretary may
2 not terminate a participation agreement or
3 in any other way discriminate against, or
4 cause to be discriminated against, any cov-
5 ered provider or authorized representative
6 of the provider, on account of such pro-
7 vider or representative—

8 (I) providing, causing to be pro-
9 vided, or being about to provide or
10 cause to be provided to the provider,
11 the Federal Government, or the attor-
12 ney general of a State information re-
13 lating to any violation of, or any act
14 or omission the provider or represent-
15 ative reasonably believes to be a viola-
16 tion of, any provision of this title (or
17 an amendment made by this title);

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

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

24 (IV) objecting to, or refusing to
25 participate in, any activity, policy,

1 practice, or assigned task that the
2 provider or representative reasonably
3 believes to be in violation of any provi-
4 sion of this Act (including any amend-
5 ment made by this Act), or any order,
6 rule, regulation, standard, or ban
7 under this Act (including any amend-
8 ment made by this Act).

9 (ii) COMPLAINT PROCEDURE.—A pro-
10 vider or representative who believes that he
11 or she has been discriminated against in
12 violation of this section may seek relief in
13 accordance with the procedures, notifica-
14 tions, burdens of proof, remedies, and stat-
15 utes of limitation set forth in section
16 2087(b) of title 15, United States Code.

17 (c) WHISTLEBLOWER PROTECTIONS.—

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

22 (A) notified the Secretary or the employ-
23 ee’s employer of any alleged violation of this
24 title, including communications related to car-
25 rying out the employee’s job duties;

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

4 (C) testified before or otherwise provided
5 information relevant for Congress or for any
6 Federal or State proceeding regarding any pro-
7 vision (or proposed provision) of this title;

8 (D) commenced, caused to be commenced,
9 or is about to commence or cause to be com-
10 menced a proceeding under this title;

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

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

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

1 tions provisions of the Surface Transportation As-
2 sistance Act.

3 (3) APPLICATION.—

4 (A) Nothing in this subsection shall be
5 construed to diminish the rights, privileges, or
6 remedies of any employee under any Federal or
7 State law or regulation, including the rights
8 and remedies against retaliatory action under
9 the False Claims Act (31 U.S.C. 3730(h)), or
10 under any collective bargaining agreement. The
11 rights and remedies in this section may not be
12 waived by any agreement, policy, form, or con-
13 dition of employment.

14 (B) Nothing in this subsection shall be
15 construed to preempt or diminish any other
16 Federal or State law or regulation against dis-
17 crimination, demotion, discharge, suspension,
18 threats, harassment, reprimand, retaliation, or
19 any other manner of discrimination, including
20 the rights and remedies against retaliatory ac-
21 tion under the False Claims Act (31 U.S.C.
22 3730(h)).

23 (4) DEFINITIONS.—In this subsection:

24 (A) EMPLOYER.—The term “employer”
25 means any person engaged in profit or non-

1 profit business or industry, including one or
2 more individuals, partnerships, associations,
3 corporations, trusts, professional membership
4 organization including a certification, discipli-
5 nary, or other professional body, unincorporated
6 organizations, nongovernmental organizations,
7 or trustees, and subject to liability for violating
8 the provisions of this Act.

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

12 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

13 (a) IN GENERAL.—A health care provider is consid-
14 ered to be qualified to furnish covered items and services
15 under this Act if the provider is licensed or certified to
16 furnish such items and services in the State in which such
17 items or services are furnished and meets—

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

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

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

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

4 (2) entities that are currently approved to co-
5 ordinate care plans under the Medicare Advantage
6 program established in Part C of Title XVIII of the
7 Social Security Act (42 U.S.C. 1851 et seq.) but do
8 not directly provide items and services of such care
9 plans.

10 (c) MINIMUM PROVIDER STANDARDS.—

11 (1) IN GENERAL.—The Secretary shall estab-
12 lish, evaluate, and update national minimum stand-
13 ards to ensure the quality of items and services pro-
14 vided under this Act and to monitor efforts by
15 States to ensure the quality of such items and serv-
16 ices. A State may establish additional minimum
17 standards which providers shall meet with respect to
18 items and services provided in such State.

19 (2) NATIONAL MINIMUM STANDARDS.—The
20 Secretary shall establish national minimum stand-
21 ards under paragraph (1) for institutional providers
22 of services and individual health care practitioners.
23 Except as the Secretary may specify in order to
24 carry out this Act, a hospital, skilled nursing facility,
25 or other institutional provider of services shall meet

1 standards applicable to such a provider under the
2 Medicare program under title XVIII of the Social
3 Security Act (42 U.S.C. 1395 et seq.). Such stand-
4 ards also may include, where appropriate, elements
5 relating to—

- 6 (A) adequacy and quality of facilities;
- 7 (B) mandatory minimum safe registered
8 nurse-to-patient staffing ratios and optimal
9 staffing levels for physicians and other health
10 care practitioners;
- 11 (C) training and competence of personnel
12 (including requirements related to the number
13 of or type of required continuing education
14 hours);
- 15 (D) comprehensiveness of service;
- 16 (E) continuity of service;
- 17 (F) patient waiting time, access to serv-
18 ices, and preferences; and
- 19 (G) performance standards, including orga-
20 nization, facilities, structure of services, effi-
21 ciency of operation, and outcome in palliation,
22 improvement of health, stabilization, cure, or
23 rehabilitation.

24 (3) TRANSITION IN APPLICATION.—If the Sec-
25 retary provides for additional requirements for pro-

1 viders under this subsection, any such additional re-
2 quirement shall be implemented in a manner that
3 provides for a reasonable period during which a pre-
4 viously qualified provider is permitted to meet such
5 an additional requirement.

6 (4) ABILITY TO PROVIDE SERVICES.—With re-
7 spect to any entity or provider certified to provide
8 items and services described in section 201(a)(7),
9 the Secretary may not prohibit such entity or pro-
10 vider from participating for reasons other than such
11 entity’s or provider’s ability to provide such items
12 and services.

13 (d) FEDERAL PROVIDERS.—Any provider qualified to
14 provide health care items and services through the Depart-
15 ment of Veterans Affairs or Indian Health Service is a
16 qualifying provider under this section with respect to any
17 individual who qualifies for such items and services under
18 applicable Federal law.

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

20 (a) IN GENERAL.—This section shall apply beginning
21 2 years after the date of the enactment of this Act.

22 (b) PARTICIPATING PROVIDERS.—

23 (1) PRIVATE CONTRACTS FOR COVERED ITEMS
24 AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An in-
25 stitutional or individual provider with an agreement

1 in effect under section 301 may not bill or enter into
2 any private contract with any individual eligible for
3 benefits under the Act for any item or service that
4 is a benefit under this Act.

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

12 (A) the contract and provider meet the re-
13 quirements specified in paragraphs (3) and (4),
14 respectively; and

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

17 (C) the provider receives—

18 (i) no reimbursement under this Act
19 directly or indirectly for such item or serv-
20 ice, and

21 (ii) receives no amount for such item
22 or service from an organization which re-
23 ceives reimbursement for such items or
24 service under this Act directly or indirectly.

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

4 (A) be in writing and signed by the indi-
5 vidual (or authorized representative of the indi-
6 vidual) receiving the item or service before the
7 item or service is furnished pursuant to the
8 contract;

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

12 (C) clearly indicate to the individual receiv-
13 ing such items and services that by signing
14 such a contract the individual—

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

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

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

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

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

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

12 (B) state that the provider will not submit
13 any claim under this Act for any noncovered
14 item or service provided to any individual en-
15 rolled under this Act;

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

19 (5) ENFORCEMENT.—If a provider signing an
20 affidavit described in paragraph (4) knowingly and
21 willfully submits a claim under this title for any item
22 or service provided or receives any reimbursement or
23 amount for any such item or service provided pursu-
24 ant to a private contract described in paragraph (2)
25 with respect to such affidavit—

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

3 (B) no payment shall be made under this
4 title for any item or service furnished by the
5 provider during the 1-year period beginning on
6 the date the affidavit was signed; and

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

10 (6) PRIVATE CONTRACTS FOR INELIGIBLE INDI-
11 VIDUALS.—An institutional or individual provider
12 with an agreement in effect under section 301 may
13 bill or enter into a private contract with any indi-
14 vidual ineligible for benefits under the Act for any
15 item or service.

16 (c) NONPARTICIPATING PROVIDERS.—

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

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

4 (A) be in writing and signed by the indi-
5 vidual (or authorized representative of the indi-
6 vidual) receiving the item or service before the
7 item or service is furnished pursuant to the
8 contract;

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

12 (C) clearly indicate to the individual receiv-
13 ing such items and services that by signing
14 such a contract the individual—

15 (i) acknowledges that the individual
16 has the right to have such items or services
17 provided by other providers for whom pay-
18 ment would be made under this Act;

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

24 (iii) agrees to be responsible for pay-
25 ment of such items or services and under-

1 stands that no reimbursement will be pro-
2 vided under this Act for such items or
3 services;

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

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

10 (3) AFFIDAVIT.—A provider who enters into a
11 contract described in paragraph (1) shall have in ef-
12 fect during the period any item or service is to be
13 provided pursuant to the contract an affidavit that
14 shall—

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

18 (B) state that the provider will not submit
19 any claim under this Act for any covered item
20 or service provided to any individual enrolled
21 under this Act during the 2-year period begin-
22 ning on the date the affidavit is signed;

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

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

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

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

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

20 **TITLE IV—ADMINISTRATION**

21 **Subtitle A—General**

22 **Administration Provisions**

23 **SEC. 401. ADMINISTRATION.**

24 (a) GENERAL DUTIES OF THE SECRETARY.—

- 1 (1) IN GENERAL.—The Secretary shall develop
2 policies, procedures, guidelines, and requirements to
3 carry out this Act, including related to—
- 4 (A) eligibility for benefits;
 - 5 (B) enrollment;
 - 6 (C) benefits provided;
 - 7 (D) provider participation standards and
8 qualifications, as described in title III;
 - 9 (E) levels of funding;
 - 10 (F) methods for determining amounts of
11 payments to providers of covered items and
12 services, consistent with subtitle B;
 - 13 (G) a process for appealing or petitioning
14 for a determination of coverage or noncoverage
15 of items and services under this Act;
 - 16 (H) planning for capital expenditures and
17 service delivery;
 - 18 (I) planning for health professional edu-
19 cation funding;
 - 20 (J) encouraging States to develop regional
21 planning mechanisms; and
 - 22 (K) any other regulations necessary to
23 carry out the purposes of this Act.

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

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

8 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-
9 PORT; STUDIES.—

10 (1) UNIFORM REPORTING STANDARDS.—

11 (A) IN GENERAL.—The Secretary shall es-
12 tablish uniform State reporting requirements
13 and national standards to ensure an adequate
14 national database containing information per-
15 taining to health services practitioners, ap-
16 proved providers, the costs of facilities and
17 practitioners providing items and services, the
18 quality of such items and services, the outcomes
19 of such items and services, and the equity of
20 health among population groups. Such database
21 shall include, to the maximum extent feasible
22 without compromising patient privacy, health
23 outcome measures used under this Act, and to
24 the maximum extent feasible without excessively
25 burdening providers, a description of the stand-

1 ards and qualifications, levels of finding, and
2 methods described in subparagraphs (D)
3 through (F) of subsection (a)(1).

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

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

20 (ii) Annual financial data that in-
21 cludes information on employees (including
22 the number of employees, hours worked,
23 and wage information) by job title and by
24 each patient care unit or department with-
25 in each facility (including outpatient units

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

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

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

21 (A) The status of implementation of the
22 Act.

23 (B) Enrollment under this Act.

24 (C) Benefits under this Act.

1 (D) Expenditures and financing under this
2 Act.

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

5 (F) Quality assurance.

6 (G) Health care utilization patterns, in-
7 cluding any changes attributable to the pro-
8 gram.

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

11 (I) Differences in the health status of the
12 populations of the different States, including in-
13 come and racial characteristics, and other popu-
14 lation health inequities.

15 (J) Progress on quality and outcome meas-
16 ures, and long-range plans and goals for
17 achievements in such areas.

18 (K) Plans for improving service to medi-
19 cally underserved populations.

20 (L) Transition problems as a result of im-
21 plementation of this Act.

22 (M) Opportunities for improvements under
23 this Act.

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

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

7 (B) develop and test methods of delivery of
8 items and services as the Secretary may con-
9 sider necessary or promising for the evaluation,
10 or for the improvement, of the operation of this
11 Act; and

12 (C) develop methodological standards for
13 policymaking.

14 (c) AUDITS.—

15 (1) IN GENERAL.—The Comptroller General of
16 the United States shall conduct an audit of the De-
17 partment of Health and Human Services every fifth
18 fiscal year following the effective date of this Act to
19 determine the effectiveness of the program in car-
20 rying out the duties under subsection (a).

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

1 **SEC. 402. CONSULTATION.**

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

17 **SEC. 403. REGIONAL ADMINISTRATION.**

18 (a) **COORDINATION WITH REGIONAL OFFICES.**—The
19 Secretary shall establish and maintain regional offices for
20 purposes of carrying out the duties specified in subsection
21 (c) and promoting adequate access to, and efficient use
22 of, tertiary care facilities, equipment, and services by indi-
23 viduals enrolled under this Act. Wherever possible, the
24 Secretary shall incorporate regional offices of the Centers
25 for Medicare & Medicaid Services for this purpose.

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

3 (1) one regional director appointed by the Sec-
4 retary; and

5 (2) one deputy director appointed by the re-
6 gional director to represent the Indian and Alaska
7 Native tribes in the region, if any.

8 (c) REGIONAL OFFICE DUTIES.—Each regional di-
9 rector shall—

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

16 (2) recommend any changes in provider reim-
17 bursement or payment for delivery of health services
18 determined appropriate by the regional director, sub-
19 ject to the provisions of title vi; and

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

1 **SEC. 404. BENEFICIARY OMBUDSMAN.**

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

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

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

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

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

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

2 In performing functions with respect to health per-
3 sonnel education and training, health research, environ-
4 mental health, disability insurance, vocational rehabilita-
5 tion, the regulation of food and drugs, and all other mat-
6 ters pertaining to health, the Secretary shall direct the ac-
7 tivities of the Department of Health and Human Services
8 toward contributions to the health of the people com-
9 plementary to this Act.

10 **Subtitle B—Control Over Fraud**
11 **and Abuse**

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

15 The following sections of the Social Security Act shall
16 apply to this Act in the same manner as they apply to
17 title XVIII or State plans under title XIX of the Social
18 Security Act:

19 (1) Section 1128 (relating to exclusion of indi-
20 viduals and entities).

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

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

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

25 (5) Section 1126 (relating to disclosure of cer-
26 tain owners).

1 (6) Section 1877 (relating to physician refer-
2 rals).

3 **TITLE V—QUALITY ASSESSMENT**

4 **SEC. 501. QUALITY STANDARDS.**

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

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

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

22 (2) Review and evaluate each standard of qual-
23 ity, performance measure, and medical review cri-
24 terion developed under part B of title IX of the Pub-
25 lic Health Service Act (42 U.S.C. 299 et seq.). In

1 so reviewing and evaluating, the Center shall deter-
2 mine whether the standard, measure, or criterion is
3 appropriate for use in assessing or reviewing the
4 quality of items and services provided by health care
5 institutions or health care professionals. The use of
6 Quality-Adjusted Life Years, Disability-Adjusted
7 Life Years, or other similar mechanisms that dis-
8 criminate against people with disabilities is prohib-
9 ited for use in any value or cost-effectiveness assess-
10 ments. The Center shall consider the evidentiary
11 basis for the standard, and the validity, reliability,
12 and feasibility of measuring the standard.

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

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

1 ordination and reporting by such entities to ensure
2 national consistency in quality standards.

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

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

9 (a) **EVALUATING DATA COLLECTION AP-**
10 **PROACHES.**—The Center shall evaluate approaches for the
11 collection of data under this Act, to be performed in con-
12 junction with existing quality reporting requirements and
13 programs under this Act, that allow for the ongoing, accu-
14 rate, and timely collection of data on disparities in health
15 care services and performance on the basis of race, eth-
16 nicity, gender, geography, disability, or socioeconomic sta-
17 tus. In conducting such evaluation, the Center shall con-
18 sider the following objectives:

19 (1) Protecting patient privacy.

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

23 (3) Improving data on race, ethnicity, gender,
24 geography, and socioeconomic status.

25 (b) **REPORTS TO CONGRESS.**—

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

8 (A) identify approaches (including defining
9 methodologies) for identifying and collecting
10 and evaluating data on health care disparities
11 on the basis of race, ethnicity, gender, geog-
12 raphy, or socioeconomic status under the Medi-
13 care for All Program; and

14 (B) include recommendations on the most
15 effective strategies and approaches to reporting
16 quality measures, as appropriate, on the basis
17 of race, ethnicity, gender, geography, or socio-
18 economic status.

19 (2) REPORT ON DATA ANALYSES.—Not later
20 than 4 years after the submission of the report
21 under subsection (b)(1), and every 4 years there-
22 after, the Center shall submit to Congress and the
23 Secretary a report that includes recommendations
24 for improving the identification of health care dis-

1 parities based on the analyses of data collected
2 under subsection (c).

3 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
4 later than 2 years after the date on which benefits first
5 become available as described in section 106(a), the Sec-
6 retary shall implement the approaches identified in the re-
7 port submitted under subsection (b)(1) for the ongoing,
8 accurate, and timely collection and evaluation of data on
9 health care disparities on the basis of race, ethnicity, gen-
10 der, geography, or socioeconomic status.

11 **TITLE VI—HEALTH BUDGET;**
12 **PAYMENTS; COST CONTAIN-**
13 **MENT MEASURES**

14 **Subtitle A—Budgeting**

15 **SEC. 601. NATIONAL HEALTH BUDGET.**

16 (a) NATIONAL HEALTH BUDGET.—

17 (1) IN GENERAL.—By not later than September
18 1 of each year, beginning with the year prior to the
19 date on which benefits first become available as de-
20 scribed in section 106(a), the Secretary shall estab-
21 lish a national health budget, which specifies a budg-
22 et for the total expenditures to be made for covered
23 health care items and services under this Act.

1 (2) DIVISION OF BUDGET INTO COMPONENTS.—

2 The national health budget shall consist of the fol-
3 lowing components:

4 (A) An operating budget.

5 (B) A capital expenditures budget.

6 (C) A special projects budget for purposes
7 of allocating funds for capital expenditures and
8 staffing needs of providers located in rural or
9 medically underserved areas (as defined in sec-
10 tion 330(b)(3) of the Public Health Service Act
11 (42 U.S.C. 254b(b)(3))), including areas des-
12 ignated as health professional shortage areas
13 (as defined in section 332(a) of the Public
14 Health Service Act (42 U.S.C. 254e(a))).

15 (D) Quality assessment activities under
16 title V.

17 (E) Health professional education expendi-
18 tures.

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

21 (G) A reserve fund to respond to the costs
22 of treating an epidemic, pandemic, natural dis-
23 aster, or other such health emergency, or mar-
24 ket-shift adjustments related to patient volume.

25 (H) Prevention and public health activities.

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

6 (A) that the operating budget allows for
7 every participating provider in the Medicare for
8 All Program to meet the needs of their respec-
9 tive patient populations;

10 (B) that the special projects budget is suf-
11 ficient to meet the health care needs within
12 areas described in paragraph (2)(C) through
13 the construction, renovation, and staffing of
14 health care facilities in a reasonable timeframe;

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

17 (D) that the health professional education
18 expenditure component is sufficient to provide
19 for the amount of health professional education
20 expenditures sufficient to meet the need for cov-
21 ered health care services.

22 (4) REGIONAL ALLOCATION.—The Secretary
23 shall annually provide each regional office with an
24 allotment the Secretary determines appropriate for
25 purposes of carrying out this Act in such region, in-

1 including payments to providers in such region, capital
2 expenditures in such region, special projects in such
3 region, health professional education in such region,
4 administrative expenses in such region, and preven-
5 tion and public health activities in such region.

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

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

10 (B) payments to individual providers pur-
11 suant to section 612.

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

15 (A) the construction or renovation of
16 health care facilities, excluding congregate or
17 segregated facilities for individuals with disabil-
18 ities who receive long term care services and
19 support; and

20 (B) major equipment purchases.

21 (7) SPECIAL PROJECTS BUDGET.—The special
22 projects budget shall be used for the construction of
23 new facilities, major equipment purchases, and staff-
24 ing in rural or medically underserved areas (as de-
25 fined in section 330(b)(3) of the Public Health Serv-

1 ice Act (42 U.S.C. 254b(b)(3))), including areas des-
2 igned as health professional shortage areas (as de-
3 fined in section 332(a) of the Public Health Service
4 Act (42 U.S.C. 254e(a))).

5 (8) TEMPORARY WORKER ASSISTANCE.—

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

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

22 (b) DEFINITIONS.—In this section:

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

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

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

10 **Subtitle B—Payments to Providers**

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

13 (a) IN GENERAL.—Not later than the beginning of
14 each fiscal quarter during which an institutional provider
15 of care (including hospitals, skilled nursing facilities, Fed-
16 erally qualified health centers, home health agencies, and
17 independent dialysis facilities) is to furnish items and
18 services under this Act, the Secretary shall pay to such
19 institutional provider a lump sum in accordance with the
20 succeeding provisions of this subsection and consistent
21 with the following:

22 (1) PAYMENT IN FULL.—Such payment shall be
23 considered as payment in full for all operating ex-
24 penses for items and services furnished under this
25 Act, whether inpatient or outpatient, by such pro-

1 vider for such quarter, including outpatient or any
2 other care provided by the institutional provider or
3 provided by any health care provider who provided
4 items and services pursuant to an agreement paid
5 through the global budget as described in paragraph
6 (3).

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

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

1 paid through such institutional provider's global
2 budget in lieu of payment under section 612 of this
3 title. Any—

4 (A) individual health care professional of
5 such group practice or other provider receiving
6 payment through an institutional provider's
7 global budget shall be paid on a salaried basis
8 that is equivalent to salaries or other compensa-
9 tion rates negotiated for individual health care
10 professionals of such institutional provider; and

11 (B) any group practice or other health care
12 provider that receives payment through an in-
13 stitutional provider global budget under this
14 paragraph shall be subject to the same report-
15 ing and disclosure requirements of the institu-
16 tional provider.

17 (b) PAYMENT AMOUNT.—

18 (1) IN GENERAL.—The amount of each pay-
19 ment to a provider described in subsection (a) shall
20 be determined before the start of each fiscal year
21 through negotiations between the provider and the
22 regional director with jurisdiction over such pro-
23 vider. Such amount shall be based on factors speci-
24 fied in paragraph (2).

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

4 (A) the historical volume of services pro-
5 vided for each item and services in the previous
6 3-year period;

7 (B) the actual expenditures of such pro-
8 vider in such provider’s most recent cost report
9 under title XVIII of the Social Security Act for
10 each item and service compared to—

11 (i) such expenditures for other institu-
12 tional providers in the director’s jurisdic-
13 tion; and

14 (ii) normative payment rates estab-
15 lished under comparative payment rate
16 systems, including any adjustments, for
17 such items and services;

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

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

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

3 (F) education and prevention programs;

4 (G) permissible adjustment to the pro-
5 vider's operating budget due to factors such
6 as—

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

9 (ii) efforts to decrease health care dis-
10 parities in rural or medically underserved
11 areas;

12 (iii) a response to emergent epidemic
13 conditions; and

14 (iv) proposed new and innovative pa-
15 tient care programs at the institutional
16 level; and

17 (H) any other factor determined appro-
18 priate by the Secretary.

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

21 (A) take into account capital expenditures
22 of the provider or any other expenditure not di-
23 rectly associated with the provision of items and
24 services by the provider to an individual;

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

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

5 (D) be used to pay or otherwise com-
6 pensate any board member, executive, or ad-
7 ministrator of the institutional provider who
8 has any interest or relationship prohibited
9 under section 301(b)(2) of this Act or disclosed
10 under section 301 of this Act.

11 (4) OPERATING EXPENSES.—For purposes of
12 this subsection, “operating expenses” of a provider
13 include the following:

14 (A) The cost of all items and services asso-
15 ciated with the provision of inpatient care and
16 outpatient care, including the following:

17 (i) Wages and salary costs for physi-
18 cians, nurses, and other health care practi-
19 tioners employed by an institutional pro-
20 vider, including mandatory minimum safe
21 registered nurse-to-patient staffing ratios
22 and optimal staffing levels for physicians
23 and other healthcare workers.

24 (ii) Wages and salary costs for all an-
25 cillary staff and services.

1 (iii) Costs of all pharmaceutical prod-
2 ucts administered by health care clinicians
3 at the institutional provider's facilities or
4 through services provided in accordance
5 with State licensing laws or regulations
6 under which the institutional provider op-
7 erates.

8 (iv) Purchasing and maintenance of
9 medical devices, supplies, and other health
10 care technologies, including diagnostic test-
11 ing equipment.

12 (v) Costs of all incidental services nec-
13 essary for safe patient care and handling.

14 (vi) Costs of patient care, education,
15 and prevention programs, including occu-
16 pational health and safety programs, public
17 health programs, and necessary staff to
18 implement such programs, for the contin-
19 ued education and health and safety of cli-
20 nicians and other individuals employed by
21 the institutional provider.

22 (B) Administrative costs for the institu-
23 tional provider.

24 (5) LIMITATION ON COMPENSATION.—Com-
25 pensation costs for any employee or any contractor

1 or any subcontractor employee of an institutional
2 provider receiving global budgets under this section
3 shall meet the compensation cap established in Sec-
4 tion 702 of the Bipartisan Budget Act of 2013 (41
5 U.S.C. 4304(a)(16)) and implementing regulations.

6 (6) REGIONAL NEGOTIATIONS PERMITTED.—
7 Subject to section 614, a regional director may nego-
8 tiate changes to an institutional provider’s global
9 budget, including any adjustments to address un-
10 foreseen market-shifts related to patient volume.

11 (c) BASELINE RATES AND ADJUSTMENTS.—

12 (1) IN GENERAL.—The Secretary shall use ex-
13 isting prospective payment systems under title
14 XVIII of the Social Security Act to serve as the
15 comparative payment rate system in global budget
16 negotiations described in subsection (b). The Sec-
17 retary shall update such comparative payment rate
18 systems annually.

19 (2) SPECIFICATIONS.—In developing the com-
20 parative payment rate system, the Secretary shall
21 use only the operating base payment rates under
22 each such prospective payment systems with applica-
23 ble adjustments.

24 (3) LIMITATION.—The comparative rate system
25 established under this subsection shall not include

1 the value-based payment adjustments and the cap-
2 ital expenses base payment rates that may be in-
3 cluded in such a prospective payment system.

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

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

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

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

7 (b) FEE SCHEDULE.—

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

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

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

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

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

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

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

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

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

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

1 lish, document, and make publicly avail-
2 able, in consultation with the Office of Pri-
3 mary Health Care, a standardized process
4 for reviewing the relative values of physi-
5 cians' services under this paragraph.

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

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

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

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

3 (c) INTERNAL TRACKING OF REVIEWS.—

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

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

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

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

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

22 (D) When relative values are adjusted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 18 (1) marketing of the provider;
19 (2) the profit or net revenue of the provider, or
20 increasing the profit or net revenue of the provider;
21 (3) incentive payments, bonuses, or other com-
22 pensation based on patient utilization of items and
23 services or any financial measure applied with re-
24 spect to the provider (or any group practice, inte-
25 grated health care delivery system, or other provider

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

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

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

11 (c) PAYMENTS FOR CAPITAL EXPENDITURES.—

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

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

1 Act (42 U.S.C. 254b(b)(3))) or to address health
2 disparities among racial, income, or ethnic groups,
3 or based on geographic regions.

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

13 (4) CAPITAL PROJECTS FUNDED BY CHARI-
14 TABLE DONATIONS.—Operating expenses and funds
15 shall not be used by an institutional provider receiv-
16 ing payment for capital expenditures under this sub-
17 section for a capital project funded by charitable do-
18 nations without the approval of the regional director
19 or directors of the region or regions where the cap-
20 ital project is located.

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

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

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

5 (e) PAYMENTS FOR SPECIAL PROJECTS.—

6 (1) IN GENERAL.—The Secretary shall allocate
7 to each regional director, from amounts made avail-
8 able for special projects pursuant to section
9 601(a)(2)(C), such sums determined appropriate by
10 the Secretary for purposes of funding projects de-
11 scribed in such section, including the construction,
12 renovation, or staffing of health care facilities, in
13 rural, underserved, or health professional or medical
14 shortage areas within such region. Each regional di-
15 rector shall, prior to distributing such funds in ac-
16 cordance with paragraph (2), present a budget de-
17 scribing how such funds will be distributed to the
18 Secretary.

19 (2) DISTRIBUTION.—A regional director shall
20 distribute funds to providers operating in the region
21 of such director's jurisdiction in a manner deter-
22 mined appropriate by the director.

23 (f) PROHIBITION ON FINANCIAL INCENTIVE
24 METRICS IN PAYMENT DETERMINATIONS.—The Sec-
25 retary may not utilize any quality metrics or standards

1 for the purposes of establishing provider payment meth-
2 odologies, programs, modifiers, or adjustments for pro-
3 vider payments under this Title.

4 **SEC. 615. OFFICE OF PRIMARY HEALTH CARE.**

5 (a) IN GENERAL.—There is established within the
6 Agency for Healthcare Research and Quality an Office of
7 Primary Health Care, responsible for coordinating with
8 the Secretary, the Health Resources and Services Admin-
9 istration, and other offices in the Department as nec-
10 essary, in order to—

11 (1) coordinate health professional education
12 policies and goals, in consultation with the Secretary
13 to achieve the national goals specified in subsection

14 (b);

15 (2) develop and maintain a system to monitor
16 the number and specialties of individuals through
17 their health professional education, any postgraduate
18 training, and professional practice;

19 (3) develop, coordinate, and promote policies
20 that expand the number of primary care practi-
21 tioners, registered nurses, midlevel practitioners, and
22 dentists;

23 (4) recommend the appropriate training, tech-
24 nical assistance, and patient protection enhance-
25 ments of primary care health professionals, including

1 registered nurses, to achieve uniform high quality
2 and patient safety; and

3 (5) consult with the Secretary on the allocation
4 of the special projects budget under section
5 601(a)(2)(C).

6 (b) NATIONAL GOALS.—Not later than 1 year after
7 the date of enactment of this Act, the Office of Primary
8 Health Care shall set forth national goals to increase ac-
9 cess to high quality primary health care, particularly in
10 underserved areas and for underserved populations.

11 (c) CLARIFICATION.—Nothing in this—

12 (1) section shall be construed to preempt any
13 provision of State law establishing practice stand-
14 ards or guidelines for health care professionals, in-
15 cluding professional licensing or practice laws or reg-
16 ulations; and

17 (2) Act shall be construed to require that any
18 State impose additional educational standards or
19 guidelines for health care professionals.

20 **SEC. 616. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
21 **PROVED DEVICES AND EQUIPMENT.**

22 The prices to be paid for covered pharmaceuticals,
23 medical supplies, medical technologies, and medically nec-
24 essary equipment covered under this Act shall be nego-
25 tiated annually by the Secretary.

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

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

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

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

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

1 (2) FINALIZATION OF NEGOTIATED PRICE.—

2 The negotiated price of each covered drug for a ne-
3 gotiated price period shall be finalized not later than
4 30 days before the first fiscal year in such nego-
5 tiated price period.

6 (3) COMPETITIVE LICENSING AUTHORITY.—

7 (A) IN GENERAL.—Notwithstanding any
8 exclusivity under clause (iii) or (iv) of section
9 505(j)(5)(F) of the Federal Food, Drug, and
10 Cosmetic Act, clause (iii) or (iv) of section
11 505(c)(3)(E) of such Act, section 351(k)(7)(A)
12 of the Public Health Service Act, or section
13 527(a) of the Federal Food, Drug, and Cos-
14 metic Act, or by an extension of such exclusivity
15 under section 505A of such Act or section 505E
16 of such Act, and any other provision of law that
17 provides for market exclusivity (or extension of
18 market exclusivity) with respect to a drug, in
19 the case that the Secretary is unable to success-
20 fully negotiate an appropriate price for a cov-
21 ered drug for a negotiated price period, the Sec-
22 retary shall authorize the use of any patent,
23 clinical trial data, or other exclusivity granted
24 by the Federal government with respect to such
25 drug as the Secretary determines appropriate

1 for purposes of manufacturing such drug for
2 sale under Medicare for All Program. Any enti-
3 ty making use of a competitive license to use
4 patent, clinical trial data, or other exclusivity
5 under this section shall provide to the manufac-
6 turer holding such exclusivity reasonable com-
7 pensation, as determined by the Secretary
8 based on the following factors:

9 (i) The risk-adjusted value of any
10 Federal government subsidies and invest-
11 ments in research and development used to
12 support the development of such drug.

13 (ii) The risk-adjusted value of any in-
14 vestment made by such manufacturer in
15 the research and development of such
16 drug.

17 (iii) The impact of the price, including
18 license compensation payments, on meeting
19 the medical need of all patients at a rea-
20 sonable cost.

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

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

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

8 (C) INTERIM PERIOD.—Until 1 year after
9 a drug described in subparagraph (A) is ap-
10 proved under section 505(j) of the Federal
11 Food, Drug, and Cosmetic Act or section
12 351(k) of the Public Health Service Act and is
13 provided under license issued by the Secretary
14 under such subparagraph, the Medicare for All
15 Program shall not pay more for such drug than
16 the average of the prices available, during the
17 most recent 12-month period for which data is
18 available prior to the beginning of such nego-
19 tiated price period, from the manufacturer to
20 any wholesaler, retailer, provider, health main-
21 tenance organization, nonprofit entity, or gov-
22 ernmental entity in the ten OECD (Organiza-
23 tion for Economic Cooperation and Develop-
24 ment) countries that have the largest gross do-
25 mestic product with a per capita income that is

1 not less than half the per capita income of the
2 United States.

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

8 (4) FDA REVIEW OF LICENSED DRUG APPLICA-
9 TIONS.—The Secretary shall prioritize review of ap-
10 plications under section 505(j) of the Federal Food,
11 Drug, and Cosmetic Act for drugs licensed under
12 paragraph (3)(A).

13 (5) PROHIBITION OF ANTICOMPETITIVE BEHAV-
14 IOR.—No drug manufacturer may engage in anti-
15 competitive behavior with another manufacturer that
16 may interfere with the issuance and implementation
17 of a competitive license or run contrary to public
18 policy.

19 (6) REQUIRED REPORTING.—The Secretary
20 may require pharmaceutical manufacturers to dis-
21 close to the Secretary such information that the Sec-
22 retary determines necessary for purposes of carrying
23 out this subsection.

1 **TITLE VII—UNIVERSAL**
2 **MEDICARE TRUST FUND**

3 **SEC. 701. UNIVERSAL MEDICARE TRUST FUND.**

4 (a) IN GENERAL.—There is hereby created on the
5 books of the Treasury of the United States a trust fund
6 to be known as the Universal Medicare Trust Fund (in
7 this section referred to as the “Trust Fund”). The Trust
8 Fund shall consist of such gifts and bequests as may be
9 made and such amounts as may be deposited in, or appro-
10 priated to, such Trust Fund as provided in this Act.

11 (b) APPROPRIATIONS INTO TRUST FUND.—

12 (1) TAXES.—There are appropriated to the
13 Trust Fund for each fiscal year beginning with the
14 fiscal year which includes the date on which benefits
15 first become available as described in section 106,
16 out of any moneys in the Treasury not otherwise ap-
17 propriated, amounts equivalent to 100 percent of the
18 net increase in revenues to the Treasury which is at-
19 tributable to the amendments made by sections 801
20 and 902. The amounts appropriated by the pre-
21 ceding sentence shall be transferred from time to
22 time (but not less frequently than monthly) from the
23 general fund in the Treasury to the Trust Fund,
24 such amounts to be determined on the basis of esti-
25 mates by the Secretary of the Treasury of the taxes

1 paid to or deposited into the Treasury, and proper
2 adjustments shall be made in amounts subsequently
3 transferred to the extent prior estimates were in ex-
4 cess of or were less than the amounts that should
5 have been so transferred.

6 (2) CURRENT PROGRAM RECEIPTS.—

7 (A) INITIAL YEAR.—Notwithstanding any
8 other provision of law, there is appropriated to
9 the Trust Fund for the fiscal year containing
10 January 1 of the first year following the date
11 of the enactment of this Act, an amount equal
12 to the aggregate amount appropriated for the
13 preceding fiscal year for the following (in-
14 creased by the consumer price index for all
15 urban consumers for the fiscal year involved):

16 (i) The Medicare program under title
17 XVIII of the Social Security Act (other
18 than amounts attributable to any pre-
19 miums under such title).

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

23 (iii) The Federal Employees Health
24 Benefits program, under chapter 89 of title
25 5, United States Code.

1 (iv) The TRICARE program, under
2 chapter 55 of title 10, United States Code.

3 (v) The maternal and child health
4 program (under title V of the Social Secu-
5 rity Act), vocational rehabilitation pro-
6 grams, programs for drug abuse and men-
7 tal health services under the Public Health
8 Service Act, programs providing general
9 hospital or medical assistance, and any
10 other Federal program identified by the
11 Secretary, in consultation with the Sec-
12 retary of the Treasury, to the extent the
13 programs provide for payment for health
14 services the payment of which may be
15 made under this Act.

16 (B) SUBSEQUENT YEARS.—Notwith-
17 standing any other provision of law, there is ap-
18 propriated to the trust fund for the fiscal year
19 containing January 1 of the second year fol-
20 lowing the date of the enactment of this Act,
21 and for each fiscal year thereafter, an amount
22 equal to the amount appropriated to the Trust
23 Fund for the previous year, adjusted for reduc-
24 tions in costs resulting from the implementation
25 of this Act, changes in the consumer price index

1 for all urban consumers for the fiscal year in-
2 volved, and other factors determined appro-
3 priate by the Secretary.

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

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

18 (d) TRANSFER OF FUNDS.—Any amounts remaining
19 in the Federal Hospital Insurance Trust Fund under sec-
20 tion 1817 of the Social Security Act (42 U.S.C. 1395i)
21 or the Federal Supplementary Medical Insurance Trust
22 Fund under section 1841 of such Act (42 U.S.C. 1395t)
23 after the payment of claims for items and services fur-
24 nished under title XVIII of such Act have been completed,

1 shall be transferred into the Universal Medicare Trust
2 Fund under this section.

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

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

11 (a) IN GENERAL.—Part 5 of subtitle B of title I of
12 the Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1131 et seq.) is amended by adding at the end
14 the following new section:

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

19 “(a) IN GENERAL.—Subject to subsection (b), no em-
20 ployee benefit plan may provide benefits that duplicate
21 payment for any items or services for which payment may
22 be made under the Medicare for All Act of 2019.

23 “(b) REIMBURSEMENT.—Each workers compensation
24 carrier that is liable for payment for workers compensa-

1 tion services furnished in a State shall reimburse the
2 Medicare for All Program for the cost of such services.

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

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

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

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

23 (b) CONFORMING AMENDMENT.—Section 4(b) of the
24 Employee Retirement Income Security Act of 1974 (29
25 U.S.C. 1003(b)) is amended by adding at the end the fol-

1 lowing: “Paragraph (3) shall apply subject to section
2 522(b) (relating to reimbursement of the Medicare for All
3 Program by workers compensation carriers).”.

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

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

7 **SEC. 802. APPLICATION OF CONTINUATION COVERAGE RE-**
8 **QUIREMENTS UNDER ERISA AND CERTAIN**
9 **OTHER REQUIREMENTS RELATING TO**
10 **GROUP HEALTH PLANS.**

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

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

21 “(c) Subsection (a) shall apply to any group health
22 plan that does not duplicate payments for any items or
23 services for which payment may be made under the Uni-
24 versal Health Insurance Act of 2017.”.

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

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

4 **TITLE IX—ADDITIONAL**
5 **CONFORMING AMENDMENTS**

6 **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**
7 **PROGRAMS.**

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

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

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

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

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

1 (D) no payment shall be made to a State
2 under section 1903(a) or 2105(a) of such Act
3 with respect to medical assistance or child
4 health assistance for any item or service fur-
5 nished on or after such date.

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

17 (3) SCHOOL PROGRAMS.—All school related
18 health programs, centers, initiatives, services, or
19 other activities or work provided under title XIX or
20 title XXI of the Social Security Act as of January
21 1, 2019 shall be continued and covered by the Medi-
22 care for All program.

23 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
24 GRAM.—No benefits shall be made available under chapter
25 89 of title 5, United States Code, with respect to items

1 and services furnished to any individual eligible to enroll
2 under this Act.

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

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

9 (1) IN GENERAL.—Nothing in this Act shall af-
10 fect the eligibility of veterans for the medical bene-
11 fits and services provided under title 38, United
12 States Code, or of Indians for the medical benefits
13 and services provided by or through the Indian
14 Health Service.

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

18 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**
19 **EXCHANGES.**

20 Effective on the date that is 2 years after the date
21 of the enactment of this Act, the Federal and State Ex-
22 changes established pursuant to title I of the Patient Pro-
23 tection and Affordable Care Act (Public Law 111–148)
24 shall terminate, and any other provision of law that relies
25 upon participation in or enrollment through such an Ex-

1 change, including such provisions of the Internal Revenue
2 Code of 1986, shall cease to have force or effect.

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

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

11 (1) the Merit-based Incentive Payment System
12 established pursuant to subsection (q) of section
13 1848 of the Social Security Act (42 U.S.C. 1395w-
14 4(q));

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

19 (3) the incentives for adoption and meaningful
20 use of certified EHR technology established pursu-
21 ant to subsection (o) of section 1848 of the Social
22 Security Act (42 U.S.C. 1395w-4(o));

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

1 (5) the following programs as established pur-
2 suant to the following sections of the Patient Protec-
3 tion and Affordable Care Act:

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

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

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

11 (D) Section 3002(b) (42 U.S.C. 1395w-
12 4(a)(8)) (incentive payments for quality report-
13 ing).

14 (E) Section 3001(a) (42 U.S.C.
15 1395ww(o)) (Hospital Value-Based Pur-
16 chasing).

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

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

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

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

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

6 (K) Section 3024 (42 U.S.C. 1395cc-5)
7 (Independence at home demonstration pro-
8 gram).

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

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

14 **TITLE X—TRANSITION**
15 **Subtitle A—Medicare for All Tran-**
16 **sition Over 2 Years and Transi-**
17 **tional Buy-in Option**

18 **SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO**
19 **YEARS.**

20 Title XVIII of the Social Security Act (42 U.S.C.
21 1395c et seq.) is amended by adding at the end the fol-
22 lowing new section:

23 **“SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2**
24 **YEARS.**

25 **“(a) TRANSITION.—**

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

7 “(2) BENEFITS.—An individual enrolled under
8 this section is entitled to the benefits established
9 under title II of the Medicare for All Act of 2019.

10 “(3) REQUIREMENTS FOR ELIGIBILITY.—The
11 requirements described in this paragraph are the fol-
12 lowing:

13 “(A) The individual meets the eligibility re-
14 quirements established by the Secretary under
15 title I of the Medicare for All Act of 2019.

16 “(B) The individual has attained the appli-
17 cable year of age, or is currently enrolled in
18 Medicare at the time of the transition to Medi-
19 care for All.

20 “(4) APPLICABLE YEAR OF AGE DEFINED.—
21 For purposes of this section, the term ‘applicable
22 year of age’ means one year after the date of enact-
23 ment of the Medicare for All Act of 2019, the age
24 of 55 or older, the age 18 or younger.

1 “(b) ENROLLMENT; COVERAGE.—The Secretary shall
2 establish enrollment periods and coverage under this sec-
3 tion consistent with the principles for establishment of en-
4 rollment periods and coverage for individuals under other
5 provisions of this title. The Secretary shall establish such
6 periods so that coverage under this section shall first begin
7 on January 1 of the year on which an individual first be-
8 comes eligible to enroll under this section.

9 “(c) SATISFACTION OF INDIVIDUAL MANDATE.—For
10 purposes of applying section 5000A of the Internal Rev-
11 enue Code of 1986, the coverage provided under this sec-
12 tion constitutes minimum essential coverage under sub-
13 section (f)(1)(A)(i) of such section 5000A.

14 “(d) CONSULTATION.—In promulgating regulations
15 to implement this section, the Secretary shall consult with
16 interested parties, including groups representing bene-
17 ficiaries, health care providers, employers, and insurance
18 companies.”.

19 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**
20 **TION BUY-IN.**

21 (a) IN GENERAL.—To carry out the purpose of this
22 section, for the year beginning one year after the date of
23 enactment of this Act and ending with the effective date
24 described in section 106(a), the Secretary, acting through
25 the Administrator of the Centers for Medicare & Medicaid

1 (referred to in this section as the “Administrator”), shall
2 establish, and provide for the offering through the Ex-
3 changes, an option to buy in to the Medicare for All Pro-
4 gram (in this Act referred to as the “Medicare Transition
5 buy-in”).

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

8 (1) ADMINISTRATOR.—The Administrator shall
9 administer the Medicare Transition buy-in in accord-
10 ance with this section.

11 (2) APPLICATION OF ACA REQUIREMENTS.—
12 Consistent with this section, the Medicare Transition
13 buy-in shall comply with requirements under title I
14 of the Patient Protection and Affordable Care Act
15 (and the amendments made by that title) and title
16 XXVII of the Public Health Service Act (42 U.S.C.
17 300gg et seq.) that are applicable to qualified health
18 plans offered through the Exchanges, subject to the
19 limitation under subsection (e)(2).

20 (3) OFFERING THROUGH EXCHANGES.—The
21 Medicare Transition buy-in shall be made available
22 only through the Exchanges, and shall be available
23 to individuals wishing to enroll and to qualified em-
24 ployers (as defined in section 1312(f)(2) of the Pa-
25 tient Protection and Affordable Care Act (42 U.S.C.

1 18032)) who wish to make such plan available to
2 their employees.

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

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

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

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

14 (d) PROVIDERS AND REIMBURSEMENT RATES.—

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

23 (2) PRESCRIPTION DRUGS.—Any payment rate
24 under this subsection for a prescription drug shall be

1 at the prices negotiated under Section 616 of this
2 Act.

3 (3) PARTICIPATING PROVIDERS.—

4 (A) IN GENERAL.—A health care provider
5 that is a participating provider of services or
6 supplier under the Medicare program under
7 title XVIII of the Social Security Act (42
8 U.S.C. 1395 et seq.) or under a State Medicaid
9 plan under title XIX of such Act (42 U.S.C.
10 1396 et seq.) on the date of enactment of this
11 Act shall be a participating provider in the
12 Medicare Transition buy-in.

13 (B) ADDITIONAL PROVIDERS.—The Ad-
14 ministrators shall establish a process to allow
15 health care providers not described in subpara-
16 graph (A) to become participating providers in
17 the Medicare Transition buy-in. Such process
18 shall be similar to the process applied to new
19 providers under the Medicare program.

20 (e) PREMIUMS.—

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

24 (A) may vary according to family or indi-
25 vidual coverage, age, and tobacco status (con-

1 sistent with clauses (i), (iii), and (iv) of section
2 2701(a)(1)(A) of the Public Health Service Act
3 (42 U.S.C. 300gg(a)(1)(A)); and

4 (B) shall take into account the cost-shar-
5 ing reductions and premium tax credits which
6 will be available with respect to the plan under
7 section 1402 of the Patient Protection and Af-
8 fordable Care Act (42 U.S.C. 18071) and sec-
9 tion 36B of the Internal Revenue Code of 1986,
10 as amended by subsection (g).

11 (2) LIMITATION.—Variation in premium rates
12 of the Medicare Transition buy-in by rating area, as
13 described in clause (ii) of section 2701(a)(1)(A)(iii)
14 of the Public Health Service Act (42 U.S.C.
15 300gg(a)(1)(A)) is not permitted.

16 (f) TERMINATION.—This section shall cease to have
17 force or effect on the effective date described in section
18 106(a).

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

20 (1) PREMIUM ASSISTANCE TAX CREDITS.—

21 (A) CREDITS ALLOWED TO MEDICARE
22 TRANSITION BUY-IN ENROLLEES IN NON-EX-
23 PANSION STATES.—Paragraph (1) of section
24 36B(c) of the Internal Revenue Code of 1986
25 is amended by redesignating subparagraphs (C)

1 and (D) as subparagraphs (D) and (E), respec-
2 tively, and by inserting after subparagraph (B)
3 the following new subparagraph:

4 “(C) SPECIAL RULES FOR MEDICARE
5 TRANSITION BUY-IN ENROLLEES.—

6 “(i) IN GENERAL.—In the case of a
7 taxpayer who is covered, or whose spouse
8 or dependent (as defined in section 152) is
9 covered, by the Medicare Transition buy-in
10 established under section 1002(a) of the
11 Medicare for All Act of 2019 for all
12 months in the taxable year, subparagraph
13 (A) shall be applied without regard to ‘but
14 does not exceed 400 percent’.

15 “(ii) ENROLLEES IN MEDICAID NON-
16 EXPANSION STATES.—In the case of a tax-
17 payer residing in a State which (as of the
18 date of the enactment of the Medicare for
19 All Act of 2019) does not provide for eligi-
20 bility under clause (i)(VIII) or (ii)(XX) of
21 section 1902(a)(10)(A) of the Social Secu-
22 rity Act for medical assistance under title
23 XIX of such Act (or a waiver of the State
24 plan approved under section 1115) who is
25 covered, or whose spouse or dependent (as

1 defined in section 152) is covered, by the
2 Medicare Transition buy-in established
3 under section 1002(a) of the Medicare for
4 All Act of 2019 for all months in the tax-
5 able year, subparagraphs (A) and (B) shall
6 be applied by substituting ‘0 percent’ for
7 ‘100 percent’ each place it appears.”

8 (B) PREMIUM ASSISTANCE AMOUNTS FOR
9 TAXPAYERS ENROLLED IN MEDICARE TRANSI-
10 TION BUY-IN.—

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

18 “(ii) SPECIAL RULES FOR TAXPAYERS
19 ENROLLED IN MEDICARE TRANSITION BUY-
20 IN.—In the case of a taxpayer who is cov-
21 ered, or whose spouse or dependent (as de-
22 fined in section 152) is covered, by the
23 Medicare Transition buy-in established
24 under section 1002(a) of the Medicare for
25 All Act of 2019 for all months in the tax-

1 able year, the applicable percentage for
 2 any taxable year shall be determined in the
 3 same manner as under clause (i), except
 4 that the following table shall apply in lieu
 5 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%	2%	2%
100% up to 138%	2.04%	2.04%
138% up to 150%	3.06%	4.08%
150% and above	4.08%	5%.”.

6 (ii) CONFORMING AMENDMENT.—Sub-
 7 clause (I) of clause (iii) of section
 8 36B(b)(3) of such Code, as redesignated
 9 by subparagraph (A)(i), is amended by in-
 10 serting “, and determined after the appli-
 11 cation of clause (ii)” after “after applica-
 12 tion of this clause”.

13 (2) COST-SHARING SUBSIDIES.—Subsection
 14 (b)of section 1402 of the Patient Protection and Af-
 15 fordable Care Act (42 U.S.C. 18071(b)) is amend-
 16 ed—

17 (A) by inserting “, or in the Medicare
 18 Transition buy-in established under section
 19 1002(a) of the Medicare for All Act of 2019,”
 20 after “coverage” in paragraph (1);

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

5 (C) by striking “INSURED.—In this sec-
6 tion” and inserting “INSURED.—
7 “(1) IN GENERAL.—In this section”;

8 (D) by striking the flush language; and

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

11 “(2) SPECIAL RULES.—

12 “(A) INDIVIDUALS LAWFULLY PRESENT.—

13 In the case of an individual described in section
14 36B(c)(1)(B) of the Internal Revenue Code of
15 1986, the individual shall be treated as having
16 household income equal to 100 percent of the
17 poverty line for a family of the size involved for
18 purposes of applying this section.

19 “(B) MEDICARE TRANSITION BUY-IN EN-
20 ROLLEES IN MEDICAID NON-EXPANSION
21 STATES.—In the case of an individual residing
22 in a State which (as of the date of the enact-
23 ment of the Medicare for All Act of 2019) does
24 not provide for eligibility under clause (i)(VIII)
25 or (ii)(XX) of section 1902(a)(10)(A) of the So-

1 cial Security Act for medical assistance under
2 title XIX of such Act (or a waiver of the State
3 plan approved under section 1115) who enrolls
4 in such Medicare Transition buy-in, the pre-
5 ceding sentence, paragraph (1)(B), and para-
6 graphs (1)(A)(i) and (2)(A) of subsection (c)
7 shall each be applied by substituting ‘0 percent’
8 for ‘100 percent’ each place it appears.”.

9 (h) CONFORMING AMENDMENTS.—

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

14 (A) in the paragraph heading, by inserting
15 “THE MEDICARE TRANSITION BUY-IN,”
16 before “AND”; and

17 (B) by inserting “The Medicare Transition
18 buy-in,” before “and a multi-State plan”.

19 (2) LEVEL PLAYING FIELD.—Section 1324(a)
20 of the Patient Protection and Affordable Care Act
21 (42 U.S.C. 18044(a)) is amended by inserting “the
22 Medicare Transition buy-in,” before “or a multi-
23 State qualified health plan”.

1 **Subtitle B—Transitional Medicare**
2 **Reforms**

3 **SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD**
4 **FOR MEDICARE COVERAGE FOR INDIVID-**
5 **UALS WITH DISABILITIES.**

6 (a) IN GENERAL.—Section 226(b) of the Social Secu-
7 rity Act (42 U.S.C. 426(b)) is amended—

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

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

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

15 (4) in the first sentence, by striking “for each
16 month beginning with the later of (I) July 1973 or
17 (II) the twenty-fifth month of his entitlement or sta-
18 tus as a qualified railroad retirement beneficiary de-
19 scribed in paragraph (2), and” and inserting “for
20 each month for which the individual meets the re-
21 quirements of paragraph (2), beginning with the
22 month following the month in which the individual
23 meets the requirements of such paragraph, and”;
24 and

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

4 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

19 (4) RAILROAD RETIREMENT SYSTEM.—Section
20 7(d)(2)(ii) of the Railroad Retirement Act of 1974
21 (45 U.S.C. 231f(d)(2)(ii)) is amended—

22 (A) by striking “has been entitled to an
23 annuity” and inserting “is entitled to an annu-
24 ity”;

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

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

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

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

13 (a) IN GENERAL.—The Secretary shall ensure that
14 all persons enrolled or who seeks to enroll in a health plan
15 during the transition period of the Medicare for All pro-
16 gram are protected from disruptions in their care during
17 the transition period, including continuity of care with
18 such persons current health care provider teams.

19 (b) CONTINUITY OF COVERAGE AND CARE IN GEN-
20 ERAL.—During the transition period of the Medicare for
21 All Act, group health plans and health insurance issuers
22 offering group or individual health insurance coverage
23 shall not end coverage for an enrollee during the transition
24 period described in the Act until all ages are eligible to

1 enroll in the Medicare for All Program except as expressly
2 agreed upon under the terms of the plan.

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

5 (1) The Secretary shall ensure that persons
6 with disabilities, complex medical needs, or chronic
7 conditions are protected from disruptions in their
8 care during the transition period, including con-
9 tinuity of care with such persons current health care
10 provider teams.

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

15 (A) end coverage for an enrollee who has
16 a disability, complex medical need, or chronic
17 condition during the transition period described
18 in the Act until all ages are eligible to enroll in
19 the Medicare for All Program; or

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

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

8 **TITLE XI—MISCELLANEOUS**

9 **SEC. 1101. DEFINITIONS.**

10 In this Act—

11 (1) the term “group practice” has the meaning
12 given such term in section 1877(h)(4) of the Social
13 Security Act (42 U.S.C. 1395m(h)(4));

14 (2) the term “individual provider” means a sup-
15 plier (as defined for purposes of paragraph (4));

16 (3) the term “institutional provider” means—
17 (A) providers of services described in sec-
18 tion 1861(u) of such Act (42 U.S.C. 1395x(u));

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

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

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

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

11 (F) independent dialysis facilities and inde-
12 pendent end-stage renal disease facilities as de-
13 scribed in 42 C.F.R. 413.174(b);

14 (4) the term “medically necessary or appro-
15 priate” means the health care items and services or
16 supplies are needed or appropriate to prevent, diag-
17 nose, or treat an illness, injury, condition, disease, or
18 its symptoms for an individual and are determined
19 to be necessary or appropriate for such individual by
20 the physician or other health care professional treat-
21 ing such individual, after such professional performs
22 an assessment of such individual’s condition, in a
23 manner that meets—

1 (A) the scope of practice, licensing, and
2 other law of the State in which such items and
3 services are to be furnished; and

4 (B) appropriate standards established by
5 the Secretary for purposes of carrying out this
6 Act.

7 (5) the term “provider” means an institutional
8 provider or a supplier (as defined in section 1861(d)
9 of such Act (42 U.S.C. 1395x(d)) if the reference to
10 “this title” were a reference to the Medicare for All
11 program);

12 (6) the term “Secretary” means the Secretary
13 of Health and Human Services;

14 (7) the term “State” means a State, the Dis-
15 trict of Columbia, or a territory of the United
16 States; and

17 (8) the term “United States” shall include the
18 States, the District of Columbia, and the territories
19 of the United States.

20 **SEC. 1102. RULES OF CONSTRUCTION.**

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

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

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

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

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

10 (5) are otherwise consistent with this Act.

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

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

23 (d) **RESTRICTIONS ON PROVIDERS.**—With respect to
24 any individuals or entities certified to provide items and
25 services covered under section 201(a)(7), a State may not

- 1 prohibit an individual or entity from participating in the
- 2 program under this Act for reasons other than the ability
- 3 of the individual or entity to provide such services.