

116TH CONGRESS
1ST SESSION

S. 1129

To establish a Medicare-for-all national health insurance program.

IN THE SENATE OF THE UNITED STATES

APRIL 10, 2019

Mr. SANDERS (for himself, Ms. BALDWIN, Mr. BLUMENTHAL, Mr. BOOKER, Mrs. GILLIBRAND, Ms. HARRIS, Mr. LEAHY, Mr. MARKEY, Mr. MERKLEY, Mr. SCHATZ, Mr. UDALL, Ms. WARREN, Mr. WHITEHOUSE, Ms. HIRONO, and Mr. HEINRICH) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To establish a 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 for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

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

- Sec. 101. Establishment of the Universal Medicare Program.
- Sec. 102. Universal entitlement.
- 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 institutional long-term care services under Medicaid.
- Sec. 205. Prohibiting recovery of correctly paid Medicaid benefits.
- Sec. 206. State standards.

TITLE III—PROVIDER PARTICIPATION

- Sec. 301. Provider participation and standards.
- 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. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

- Sec. 411. Application of Federal sanctions to all fraud and abuse under Universal Medicare 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 and individual providers.
- Sec. 612. Ensuring accurate valuation of services under the Medicare physician fee schedule.
- Sec. 613. Office of primary health care.
- Sec. 614. 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 Universal Medicare Program; coordination in case of workers' compensation.
- Sec. 802. Repeal 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.

TITLE X—TRANSITION

Subtitle A—Transitional Medicare Buy-In Option and Transitional Public Option

- Sec. 1001. Lowering the Medicare age.
- Sec. 1002. Establishment of the Medicare transition plan.

Subtitle B—Transitional Medicare Reforms

- Sec. 1011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits and elimination of parts A and B deductibles.
- Sec. 1012. Reduction in Medicare part D annual out-of-pocket threshold and elimination of cost-sharing above that threshold.
- Sec. 1013. Coverage of dental and vision services and hearing aids and examinations under Medicare part B.
- Sec. 1014. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
- Sec. 1015. Guaranteed issue of Medigap policies.

Subtitle C—Private Health Insurance Availability During Transitional Period

- Sec. 1021. Continuity of care.

TITLE XI—MISCELLANEOUS

- Sec. 1101. Updating resource limits for Supplemental Security Income eligibility (SSI).
- Sec. 1102. Definitions.

1 **TITLE I—ESTABLISHMENT OF**
 2 **THE UNIVERSAL MEDICARE**
 3 **PROGRAM; UNIVERSAL ENTI-**
 4 **TLEMENT; ENROLLMENT**

5 **SEC. 101. ESTABLISHMENT OF THE UNIVERSAL MEDICARE**
 6 **PROGRAM.**

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

12 **SEC. 102. UNIVERSAL ENTITLEMENT.**

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

18 (b) TREATMENT OF OTHER INDIVIDUALS.—The Sec-
 19 retary—

20 (1) may make eligible for benefits for health
 21 care services under this Act other individuals not de-
 22 scribed in subsection (a) and regulate their eligibility
 23 to ensure that every person in the United States has
 24 access to health care; and

1 (2) shall promulgate a rule, consistent with
2 Federal immigration laws, to prevent an individual
3 from traveling to the United States for the sole pur-
4 pose of obtaining health care services provided under
5 this Act.

6 **SEC. 103. FREEDOM OF CHOICE.**

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

10 **SEC. 104. NON-DISCRIMINATION.**

11 (a) IN GENERAL.—No person shall, on the basis of
12 race, color, national origin, age, disability, or sex, includ-
13 ing sex stereotyping, gender identity, sexual orientation,
14 and pregnancy and related medical conditions (including
15 termination of pregnancy), be excluded from participation
16 in, be denied the benefits of, or be subjected to discrimina-
17 tion by any participating provider as defined in section
18 301, or any entity conducting, administering, or funding
19 a health program or activity, including contracts of insur-
20 ance, pursuant to this Act.

21 (b) CLAIMS OF DISCRIMINATION.—

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

1 (2) JURISDICTION.—Any person aggrieved by a
 2 violation of subsection (a) by a covered entity may
 3 file suit in any district court of the United States
 4 having jurisdiction of the parties.

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

10 **SEC. 105. ENROLLMENT.**

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

14 (1) include a process for the automatic enroll-
 15 ment of individuals at the time of birth in the
 16 United States or upon the establishment of resi-
 17 dency in the United States;

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

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

24 (b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—
 25 In conjunction with an individual’s enrollment for benefits

1 under this Act, the Secretary shall provide for the issuance
2 of a Universal Medicare card that shall be used for pur-
3 poses of identification and processing of claims for bene-
4 fits under this program. The card shall not include an in-
5 dividual's Social Security number.

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

7 (a) IN GENERAL.—Except as provided in subsection
8 (b), benefits shall first be available under this Act for
9 items and services furnished on January 1 of the fourth
10 calendar year that begins after the date of enactment of
11 this Act.

12 (b) COVERAGE FOR CHILDREN.—

13 (1) IN GENERAL.—For any eligible individual
14 who has not yet attained the age of 19, benefits
15 shall first be available under this Act for items and
16 services furnished on January 1 of the first calendar
17 year that begins after the date of enactment of this
18 Act.

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

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

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

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

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

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

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

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

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

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

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

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

9 (2) Ambulatory patient services.

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

12 (4) Prescription drugs, medical devices, biologi-
13 cal products, including outpatient prescription drugs,
14 medical devices, and biological products.

15 (5) Mental health and substance abuse treat-
16 ment services, including inpatient care.

17 (6) Laboratory and diagnostic services.

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

20 (8) Pediatrics, including early and periodic
21 screening, diagnostic, and treatment services (as de-
22 fined in section 1905(r) of the Social Security Act
23 (42 U.S.C. 1396d(r))).

24 (9) Oral health, audiology, and vision services.

1 (10) Short-term rehabilitative and habilitative
2 services and devices.

3 (11) Emergency services and transportation.

4 (12) Necessary transportation to receive health
5 care services for individuals with disabilities and low-
6 income individuals.

7 (13) Home and community-based long-term
8 services and supports (to be provided in accordance
9 with the requirements for home and community-
10 based settings under sections 441.530 and 441.710
11 of title 42, Code of Federal Regulations), includ-
12 ing—

13 (A) services described in paragraphs (7),
14 (8), (13), (19), and (24) of section 1905(a) of
15 the Social Security Act (42 U.S.C. 1396d(a));

16 (B) home and community-based services
17 described in subsection (c)(4)(B) of section
18 1915 of the Social Security Act (including ha-
19 bilitation services defined in subsection (c)(5) of
20 such section);

21 (C) self-directed home and community-
22 based services described in subsection (i) of sec-
23 tion 1915 of the Social Security Act;

1 (D) self-directed personal assistance serv-
2 ices (as defined in subsection (j)(4)(A) of sec-
3 tion 1915 of the Social Security Act); and

4 (E) home and community-based attendant
5 services and supports described in subsection
6 (k) of section 1915 of the Social Security Act.

7 (b) REVISION AND ADJUSTMENT.—The Secretary
8 shall, on a regular basis, evaluate whether the benefits
9 package should be improved or adjusted to promote the
10 health of beneficiaries, account for changes in medical
11 practice or new information from medical research, or re-
12 spond to other relevant developments in health science,
13 and shall make recommendations to Congress regarding
14 any such improvements or adjustments.

15 (c) COMPLEMENTARY AND INTEGRATIVE MEDI-
16 CINE.—

17 (1) IN GENERAL.—In carrying out subsection
18 (b), the Secretary shall consult with the persons de-
19 scribed in paragraph (1) with respect to—

20 (A) identifying specific complementary and
21 integrative medicine practices that, on the basis
22 of research findings or promising clinical inter-
23 ventions, are appropriate to include in the bene-
24 fits package; and

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

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

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

9 (B) the Commissioner of Food and Drugs;

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

16 (D) nationally recognized providers of com-
17plementary and integrative medicine; and

18 (E) such other officials, entities, and indi-
19viduals with expertise on complementary and
20integrative medicine as the Secretary deter-
21mines appropriate.

22 (d) STATES MAY PROVIDE ADDITIONAL BENE-
23 FITS.—Individual States may provide additional benefits
24 for the residents of such States at the expense of the
25 State.

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

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

7 (b) EXCEPTIONS.—The Secretary may set a cost-
8 sharing schedule for prescription drugs and biological
9 products—

10 (1) provided that—

11 (A) such schedule is evidence-based and
12 encourages the use of generic drugs;

13 (B) such cost-sharing does not apply to
14 preventive drugs;

15 (C) such cost-sharing does not exceed \$200
16 annually per individual, adjusted annually for
17 inflation; and

18 (D) such cost-sharing is not imposed on in-
19 dividuals with a household income equal to or
20 below 200 percent of the poverty line for a fam-
21 ily of the size involved; and

22 (2) under which the Secretary may exempt
23 brand-name drugs from consideration in determining
24 whether an individual has reached any out-of-pocket
25 limit if a generic version of such drug is available.

1 (c) NO BALANCE BILLING.—Notwithstanding con-
 2 tracts in accordance with section 303, no provider may
 3 impose a charge to an enrolled individual for covered serv-
 4 ices for which benefits are provided under this Act.

5 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

6 (a) IN GENERAL.—Benefits for services are not avail-
 7 able under this Act unless the services meet the standards
 8 specified in section 201(a), as defined by the Secretary.

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

11 (1) IN GENERAL.—In applying subsection (a),
 12 the Secretary shall make national coverage deter-
 13 minations with respect to services that are experi-
 14 mental in nature. Such determinations shall be con-
 15 sistent 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 process for appeals under the Medi-
 22 care program described in section 1869 of the Social
 23 Security Act (42 U.S.C. 1395ff).

24 (c) APPLICATION OF PRACTICE GUIDELINES.—In the
 25 case of services for which the Department of Health and

1 Human Services has recognized a national practice guide-
 2 line, the services are considered to meet the standards
 3 specified in section 201(a) if they have been provided in
 4 accordance with such guideline. For purposes of this sub-
 5 section, a service shall be considered to have been provided
 6 in accordance with a practice guideline if the health care
 7 provider providing the service exercised appropriate pro-
 8 fessional discretion to deviate from the guideline in a man-
 9 ner authorized or anticipated by the guideline.

10 **SEC. 204. COVERAGE OF INSTITUTIONAL LONG-TERM CARE**
 11 **SERVICES UNDER MEDICAID.**

12 Title XIX of the Social Security Act (42 U.S.C. 1396
 13 et seq.) is amended by inserting the following section after
 14 section 1946:

15 “STATE PLAN FOR PROVIDING INSTITUTIONAL LONG-
 16 TERM CARE SERVICES

17 “SEC. 1947. (a) IN GENERAL.—For quarters begin-
 18 ning on or after date on which benefits are first available
 19 under section 106(a) of the Medicare for All Act of 2019,
 20 notwithstanding any other provision of this title—

21 “(1) a State plan for medical assistance shall
 22 provide for making medical assistance available for
 23 services that are institutional long-term care services
 24 in a manner consistent with this section; and

25 “(2) no payment to a State shall be made
 26 under this title with respect to expenditures incurred

1 by the State in providing medical assistance on or
2 after such date for services that are not—

3 “(A) institutional long-term care services;

4 or

5 “(B) other services for which benefits are
6 not available under the Medicare for All Act of
7 2019 and which are furnished under a State
8 plan for medical assistance which provided for
9 medical assistance for such services on Sep-
10 tember 1, 2018.

11 “(b) INSTITUTIONAL LONG-TERM CARE SERVICES
12 DEFINED.—In this section, the term ‘institutional long-
13 term care services’ means the following:

14 “(1) Nursing facility services for individuals 21
15 years of age or over described in subparagraph (A)
16 of section 1905(a)(4).

17 “(2) Inpatient services for individuals 65 years
18 of age or over provided in an institution for mental
19 disease described in section 1905(a)(14).

20 “(3) Intermediate care facility services de-
21 scribed in section 1905(a)(15).

22 “(4) Inpatient psychiatric hospital services for
23 individuals under age 21 described in section
24 1905(a)(16).

1 “(5) Nursing facility services described in sec-
2 tion 1905(a)(29).

3 “(c) MAINTENANCE OF EFFORT.—

4 “(1) ELIGIBILITY STANDARDS.—

5 “(A) IN GENERAL.—Beginning on the date
6 described in subsection (a), no payment may be
7 made under section 1903 with respect to med-
8 ical assistance provided under a State plan for
9 medical assistance if the State adopts income,
10 resource, or other standards and methodologies
11 for purposes of determining an individual’s eli-
12 gibility for medical assistance under the State
13 plan that are more restrictive than those ap-
14 plied as of January 1, 2019.

15 “(B) INDEXING OF AMOUNTS OF INCOME
16 AND RESOURCE STANDARDS.—In determining
17 whether a State has adopted income or resource
18 standards that are more restrictive than the
19 standards which applied as of January 1, 2019,
20 the Secretary shall deem the amount of any
21 such standard that was applied as of such date
22 to be increased by the percentage increase in
23 the medical care component of the consumer
24 price index for all urban consumers (U.S. city
25 average) from September of 2018 to September

1 of the fiscal year for which the Secretary is
2 making such determination.

3 “(2) EXPENDITURES.—

4 “(A) IN GENERAL.—For each fiscal year
5 or portion of a fiscal year that occurs during
6 the period that begins on the first day of the
7 first fiscal quarter that begins on or after the
8 date on which benefits are first available under
9 section 106(a) of the Medicare for All Act of
10 2019, as a condition of receiving payments
11 under section 1903(a), a State shall make ex-
12 penditures for medical assistance for services
13 that are institutional long-term care services in
14 an amount that is not less than the expenditure
15 floor determined for the State and fiscal year
16 (or portion of a fiscal year) under subparagraph
17 (B).

18 “(B) EXPENDITURE FLOOR.—

19 “(i) IN GENERAL.—For each fiscal
20 year or portion of a fiscal year described in
21 subparagraph (A), the Secretary shall de-
22 termine for each State an expenditure floor
23 that shall be equal to—

24 “(I) the amount of the State’s
25 expenditures for fiscal year 2018 on

1 medical assistance for institutional
2 long-term care services; increased by

3 “(II) the growth factor deter-
4 mined under subclause (ii).

5 “(ii) GROWTH FACTOR.—For each fis-
6 cal year or portion of a fiscal year de-
7 scribed in subparagraph (A), the Secretary
8 shall, not later than September 1 of the
9 fiscal year preceding such fiscal year or
10 portion of a fiscal year, determine a
11 growth factor for each State that takes
12 into account—

13 “(I) the percentage increase in
14 health care costs in the State;

15 “(II) the total amount expended
16 by the State for the previous fiscal
17 year on medical assistance for institu-
18 tional long-term care services;

19 “(III) the increase, if any, in the
20 total population of the State from
21 July of 2018 to July of the fiscal year
22 preceding the fiscal year involved;

23 “(IV) the increase, if any, in the
24 population of individuals aged 65 and
25 older of the State from July of 2018

1 to July of the fiscal year preceding
 2 the fiscal year involved; and

3 “(V) the decrease, if any, in the
 4 population of the State that requires
 5 medical assistance for institutional
 6 long-term care services that is attrib-
 7 utable to the availability of coverage
 8 for the services described in section
 9 201(a)(13) of the Medicare for All
 10 Act of 2019.

11 “(iii) PRORATION RULE.—Any
 12 amount determined under this subpara-
 13 graph for a portion of a fiscal year shall be
 14 prorated based on the length of such por-
 15 tion of a fiscal year relative to a complete
 16 fiscal year.

17 “(d) NONAPPLICATION OF CERTAIN REQUIRE-
 18 MENTS.—Beginning on the date described in subsection
 19 (a), any provision of this title requiring a State plan for
 20 medical assistance to make available medical assistance
 21 for services that are not institutional long-term care serv-
 22 ices or services described in section 901(a)(3)(A)(ii) of the
 23 Medicare for All Act of 2019 shall have no effect.”.

1 **SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID**
2 **MEDICAID BENEFITS.**

3 Section 1917 of the Social Security Act (42 U.S.C.
4 1396p) is amended—

5 (1) by amending subsection (a) to read as fol-
6 lows:

7 “(a) No lien may be imposed against the property
8 of any individual prior to his death on account of medical
9 assistance paid or to be paid on his behalf under the State
10 plan, except pursuant to the judgment of a court on ac-
11 count of benefits incorrectly paid on behalf of such indi-
12 vidual.”; and

13 (2) by amending subsection (b) to read as fol-
14 lows:

15 “(b) No adjustment or recovery of any medical assist-
16 ance correctly paid on behalf of an individual under the
17 State plan may be made.”.

18 **SEC. 206. STATE STANDARDS.**

19 (a) IN GENERAL.—Nothing in this Act shall prohibit
20 individual States from setting additional standards, with
21 respect to eligibility, benefits, and minimum provider
22 standards, consistent with the purposes of this Act, pro-
23 vided that such standards do not restrict eligibility or re-
24 duce access to benefits or services.

25 (b) RESTRICTIONS ON PROVIDERS.—With respect to
26 any individuals or entities certified to provide services cov-

1 ered under section 201(a)(7), a State may not prohibit
 2 an individual or entity from participating in the program
 3 under this Act, for reasons other than the ability of the
 4 individual or entity to provide such services.

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

7 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.**

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

11 (1) is a qualified provider of the services under
 12 section 302;

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

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

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

22 (1) IN GENERAL.—A participation agreement
 23 described in this subsection between the Secretary
 24 and a provider shall provide at least for the fol-
 25 lowing:

1 (A) Services to eligible persons will be fur-
2 nished by the provider without discrimination,
3 in accordance with section 104(a). Nothing in
4 this subparagraph shall be construed as requir-
5 ing the provision of a type or class of services
6 that are outside the scope of the provider's nor-
7 mal practice.

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

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

16 (i) quality review by designated enti-
17 ties;

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

23 (iii) statistical or other studies re-
24 quired for the implementation of this Act;
25 and

1 (iv) such other purposes as the Sec-
 2 retary may specify.

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

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

15 (2) TERMINATION OF PARTICIPATION AGREE-
 16 MENT.—

17 (A) IN GENERAL.—Participation agree-
 18 ments may be terminated, with appropriate no-
 19 tice—

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

22 (ii) by a provider.

23 (B) TERMINATION PROCESS.—Providers
 24 shall be provided notice and a reasonable oppor-
 25 tunity to correct deficiencies before the Sec-

1 retary terminates an agreement unless a more
2 immediate termination is required for public
3 safety or similar reasons.

4 (C) PROVIDER PROTECTIONS.—

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

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

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

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

4 (IV) objecting to, or refusing to
 5 participate in, any activity, policy,
 6 practice, or assigned task that the
 7 provider or representative reasonably
 8 believes to be in violation of any provi-
 9 sion of this Act (including any amend-
 10 ment made by this Act), or any order,
 11 rule, regulation, standard, or ban
 12 under this Act (including any amend-
 13 ment made by this Act).

14 (ii) COMPLAINT PROCEDURE.—A pro-
 15 vider or representative who believes that he
 16 or she has been discriminated against in
 17 violation of this section may seek relief in
 18 accordance with the procedures, notifica-
 19 tions, burdens of proof, remedies, and stat-
 20 utes of limitation set forth in section
 21 2087(b) of title 15, United States Code.

22 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

23 (a) IN GENERAL.—A health care provider is consid-
 24 ered to be qualified to provide covered services if the pro-
 25 vider is licensed or certified and meets—

1 (1) all the requirements of State law to provide
2 such services; and

3 (2) applicable requirements of Federal law to
4 provide such services.

5 (b) MINIMUM PROVIDER STANDARDS.—

6 (1) IN GENERAL.—The Secretary shall estab-
7 lish, evaluate, and update national minimum stand-
8 ards to ensure the quality of services provided under
9 this Act and to monitor efforts by States to ensure
10 the quality of such services. A State may also estab-
11 lish additional minimum standards which providers
12 shall meet with respect to services provided in such
13 State.

14 (2) NATIONAL MINIMUM STANDARDS.—The na-
15 tional minimum standards under paragraph (1) shall
16 be established for institutional providers of services
17 and individual health care practitioners. Except as
18 the Secretary may specify in order to carry out this
19 Act, a hospital, skilled nursing facility, or other in-
20 stitutional provider of services shall meet standards
21 for such a provider under the Medicare program
22 under title XVIII of the Social Security Act (42
23 U.S.C. 1395 et seq.). Such standards also may in-
24 clude, where appropriate, elements relating to—

25 (A) adequacy and quality of facilities;

- 1 (B) training and competence of personnel
- 2 (including continuing education requirements);
- 3 (C) comprehensiveness of service;
- 4 (D) continuity of service;
- 5 (E) patient satisfaction, including waiting
- 6 time and access to services; and
- 7 (F) performance standards, including orga-
- 8 nization, facilities, structure of services, effi-
- 9 ciency of operation, and outcome in palliation,
- 10 improvement of health, stabilization, cure, or
- 11 rehabilitation.

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

19 (4) ABILITY TO PROVIDE SERVICES.—With re-
 20 spect to any entity or provider certified to provide
 21 services described in section 201(a)(7), the Secretary
 22 may not prohibit such entity or provider from par-
 23 ticipating for reasons other than its ability to pro-
 24 vide such services.

1 (c) **FEDERAL PROVIDERS.**—Any provider qualified to
 2 provide health care services through the Department of
 3 Veterans Affairs or Indian Health Service is a qualifying
 4 provider under this section with respect to any individual
 5 who qualifies for such services under applicable Federal
 6 law.

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

8 (a) **IN GENERAL.**—Subject to the provisions of this
 9 subsection, nothing in this Act shall prohibit an institu-
 10 tional or individual provider from entering into a private
 11 contract with an enrolled individual for any item or serv-
 12 ice—

13 (1) for which no claim for payment is to be sub-
 14 mitted under this Act; and

15 (2) for which the provider receives—

16 (A) no reimbursement under this Act di-
 17 rectly or on a capitated basis; and

18 (B) receives no amount for such item or
 19 service from an organization which receives re-
 20 imbursement for such items or service under
 21 this Act directly or on a capitated basis.

22 (b) **BENEFICIARY PROTECTIONS.**—

23 (1) **IN GENERAL.**—Subsection (a) shall not
 24 apply to any contract unless—

1 (A) the contract is in writing and is signed
2 by the beneficiary before any item or service is
3 provided pursuant to the contract;

4 (B) the contract contains the items de-
5 scribed in paragraph (2); and

6 (C) the contract is not entered into at a
7 time when the beneficiary is facing an emer-
8 gency health care situation.

9 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-
10 TRACT.—Any contract to provide items and services
11 to which subsection (a) applies shall clearly indicate
12 to the beneficiary that by signing such contract the
13 beneficiary—

14 (A) agrees not to submit a claim (or to re-
15 quest that the provider submit a claim) under
16 this Act for such items or services even if such
17 items or services are otherwise covered by this
18 Act;

19 (B) agrees to be responsible, whether
20 through insurance offered under section 107(b)
21 or otherwise, for payment of such items or serv-
22 ices and understands that no reimbursement
23 will be provided under this Act for such items
24 or services;

1 (C) acknowledges that no limits under this
 2 Act apply to amounts that may be charged for
 3 such items or services;

4 (D) if the provider is a non-participating
 5 provider, acknowledges that the beneficiary has
 6 the right to have such items or services pro-
 7 vided by other providers for whom payment
 8 would be made under this Act; and

9 (E) acknowledges that the provider is pro-
 10 viding services outside the scope of the program
 11 under this Act.

12 (c) PROVIDER REQUIREMENTS.—

13 (1) IN GENERAL.—Subsection (a) shall not
 14 apply to any contract unless an affidavit described
 15 in paragraph (2) is in effect during the period any
 16 item or service is to be provided pursuant to the
 17 contract.

18 (2) AFFIDAVIT.—An affidavit is described in
 19 this subparagraph shall—

20 (A) identify the practitioner, and be signed
 21 by such practitioner;

22 (B) provide that the practitioner will not
 23 submit any claim under this title for any item
 24 or service provided to any beneficiary (and will
 25 not receive any reimbursement or amount de-

1 scribed in paragraph (1)(B) for any such item
 2 or service) during the 1-year period beginning
 3 on the date the affidavit is signed; and

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

7 (3) ENFORCEMENT.—If a physician or practi-
 8 tioner signing an affidavit described in paragraph
 9 (2) knowingly and willfully submits a claim under
 10 this title for any item or service provided during the
 11 1-year period described in paragraph (2)(B) (or re-
 12 ceives any reimbursement or amount described in
 13 subsection (a)(2) for any such item or service) with
 14 respect to such affidavit—

15 (A) this subsection shall not apply with re-
 16 spect to any items and services provided by the
 17 physician or practitioner pursuant to any con-
 18 tract on and after the date of such submission
 19 and before the end of such period; and

20 (B) no payment shall be made under this
 21 title for any item or service furnished by the
 22 physician or practitioner during the period de-
 23 scribed in clause (i) (and no reimbursement or
 24 payment of any amount described in subsection

1 (a)(2) shall be made for any such item or serv-
 2 ice).

3 **TITLE IV—ADMINISTRATION**

4 **Subtitle A—General**

5 **Administration Provisions**

6 **SEC. 401. ADMINISTRATION.**

7 (a) GENERAL DUTIES OF THE SECRETARY.—

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

11 (A) eligibility for benefits;

12 (B) enrollment;

13 (C) benefits provided;

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

16 (E) levels of funding;

17 (F) methods for determining amounts of
 18 payments to providers of covered services, con-
 19 sistent with subtitle B;

20 (G) the determination of medical necessity
 21 and appropriateness with respect to coverage of
 22 certain services;

23 (H) planning for capital expenditures and
 24 service delivery;

1 (I) planning for health professional edu-
2 cation funding;

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

5 (K) any other regulations necessary to
6 carry out the purpose of this Act.

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

10 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-
11 PORT; STUDIES.—

12 (1) UNIFORM REPORTING STANDARDS.—

13 (A) IN GENERAL.—The Secretary shall es-
14 tablish uniform State reporting requirements
15 and national standards to ensure an adequate
16 national database containing information per-
17 taining to health services practitioners, ap-
18 proved providers, the costs of facilities and
19 practitioners providing such services, the qual-
20 ity of such services, the outcomes of such serv-
21 ices, and the equity of health among population
22 groups. Such standards shall include, to the
23 maximum extent feasible without compromising
24 patient privacy, health outcome measures, and
25 to the maximum extent feasible without exces-

1 sively burdening providers, the measures de-
2 scribed in subparagraphs (D) through (F) of
3 subsection (a)(1).

4 (B) REPORTS.—The Secretary shall regu-
5 larly analyze information reported to it and
6 shall define rules and procedures to allow re-
7 searchers, scholars, health care providers, and
8 others to access and analyze data for purposes
9 consistent with quality and outcomes research,
10 without compromising patient privacy.

11 (2) ANNUAL REPORT.—Beginning January 1 of
12 the second year beginning after the effective date of
13 this Act, the Secretary shall annually report to Con-
14 gress on the following:

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

17 (B) Enrollment under this Act.

18 (C) Benefits under this Act.

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

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

23 (F) Quality assurance.

1 (G) Health care utilization patterns, in-
 2 cluding any changes attributable to the pro-
 3 gram.

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

6 (I) Differences in the health status of the
 7 populations of the different States, including in-
 8 come and racial characteristics, and other popu-
 9 lation health inequities.

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

13 (K) Necessary changes in the education of
 14 health personnel.

15 (L) Plans for improving service to medi-
 16 cally underserved populations.

17 (M) Transition problems as a result of im-
 18 plementation of this Act.

19 (N) Opportunities for improvements under
 20 this Act.

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

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

4 (B) develop and test methods of payment
5 or delivery as it may consider necessary or
6 promising for the evaluation, or for the im-
7 provement, of the operation of this Act; and

8 (C) develop methodological standards for
9 evidence-based policymaking.

10 (c) AUDITS.—

11 (1) IN GENERAL.—The Comptroller General of
12 the United States shall conduct an audit of the
13 Board every fifth fiscal year following the effective
14 date of this Act to determine the effectiveness of the
15 program in carrying out the duties under subsection
16 (a).

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

21 **SEC. 402. CONSULTATION.**

22 The Secretary shall consult with Federal agencies,
23 Indian tribes and urban Indian health organizations, and
24 private entities, such as professional societies, national as-
25 sociations, nationally recognized associations of experts,

1 medical schools and academic health centers, consumer
2 and patient groups, and labor and business organizations
3 in the formulation of guidelines, regulations, policy initia-
4 tives, and information gathering to ensure the broadest
5 and most informed input in the administration of this Act.
6 Nothing in this Act shall prevent the Secretary from
7 adopting guidelines developed by such a private entity if,
8 in the Secretary's judgment, such guidelines are generally
9 accepted as reasonable and prudent and consistent with
10 this Act.

11 **SEC. 403. REGIONAL ADMINISTRATION.**

12 (a) COORDINATION WITH REGIONAL OFFICES.—The
13 Secretary shall establish and maintain regional offices to
14 promote adequate access to, and efficient use of, tertiary
15 care facilities, equipment, and services. Wherever possible,
16 the Secretary shall incorporate regional offices of the Cen-
17 ters for Medicare & Medicaid Services for this purpose.

18 (b) APPOINTMENT OF REGIONAL AND STATE DIREC-
19 TORS.—In each such regional office there shall be—

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

22 (2) for each State in the region, a deputy direc-
23 tor; and

24 (3) one deputy director to represent the Native
25 American and Alaska Native tribes in the region.

1 (c) REGIONAL OFFICE DUTIES.—Regional offices
2 shall be responsible for—

3 (1) providing an annual State health care needs
4 assessment report to the Secretary, after a thorough
5 examination of health needs, in consultation with
6 public health officials, clinicians, patients, and pa-
7 tient advocates;

8 (2) recommending changes in provider reim-
9 bursement or payment for delivery of health services
10 in the States within the region; and

11 (3) establishing a quality assurance mechanism
12 in the State in order to minimize both under-utiliza-
13 tion and over-utilization and to ensure that all pro-
14 viders meet high-quality standards.

15 **SEC. 404. BENEFICIARY OMBUDSMAN.**

16 (a) IN GENERAL.—The Secretary shall appoint a
17 Beneficiary Ombudsman who shall have expertise and ex-
18 perience in the fields of health care and education of, and
19 assistance to, individuals entitled to benefits under this
20 Act.

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

22 (1) receive complaints, grievances, and requests
23 for information submitted by individuals entitled to
24 benefits under this Act with respect to any aspect of
25 the Universal Medicare Program;

1 (2) provide assistance with respect to com-
 2 plaints, grievances, and requests referred to in sub-
 3 paragraph (a), including—

4 (A) assistance in collecting relevant infor-
 5 mation for such individuals, to seek an appeal
 6 of a decision or determination made by a re-
 7 gional office or the Secretary; and

8 (B) assistance to such individuals in pre-
 9 senting information under relating to cost-shar-
 10 ing; and

11 (3) submit annual reports to Congress and the
 12 Secretary that describe the activities of the Office
 13 and that include such recommendations for improve-
 14 ment in the administration of this Act as the Om-
 15 budsman determines appropriate. The Ombudsman
 16 shall not serve as an advocate for any increases in
 17 payments or new coverage of services, but may iden-
 18 tify issues and problems in payment or coverage
 19 policies.

20 **SEC. 405. COMPLEMENTARY CONDUCT OF RELATED**
 21 **HEALTH PROGRAMS.**

22 In performing functions with respect to health per-
 23 sonnel education and training, health research, environ-
 24 mental health, disability insurance, vocational rehabilita-
 25 tion, the regulation of food and drugs, and all other mat-

ters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER UNIVERSAL MEDICAL CARE PROGRAM.

The following sections of the Social Security Act shall apply to this Act in the same manner as they apply to State medical assistance plans under title XIX of such Act:

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

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

(3) Section 1128B (criminal penalties).

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

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

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be performed by the Center for

1 Clinical Standards and Quality of the Centers for Medi-
 2 care & Medicaid Services (referred to in this title as the
 3 “Center”), in coordination with the Agency for Healthcare
 4 Research and Quality and other offices of the Department
 5 of Health and Human Services.

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

8 (1) PRACTICE GUIDELINES.—The Center shall
 9 review and evaluate each practice guideline devel-
 10 oped under part B of title IX of the Public Health
 11 Service Act. The Center shall determine whether the
 12 guideline should be recognized as a national practice
 13 guideline.

14 (2) STANDARDS OF QUALITY, PERFORMANCE
 15 MEASURES, AND MEDICAL REVIEW CRITERIA.—The
 16 Center shall review and evaluate each standard of
 17 quality, performance measure, and medical review
 18 criterion developed under part B of title IX of the
 19 Public Health Service Act (42 U.S.C. 299 et seq.).
 20 The Center shall determine whether the standard,
 21 measure, or criterion is appropriate for use in as-
 22 sessing or reviewing the quality of services provided
 23 by health care institutions or health care profes-
 24 sionals. In evaluating such standards, the Center
 25 shall consider the evidentiary basis for the standard,

1 and the validity, reliability, and feasibility of meas-
2 uring the standard.

3 (3) PROFILING OF PATTERNS OF PRACTICE;
4 IDENTIFICATION OF OUTLIERS.—The Center shall
5 adopt methodologies for profiling the patterns of
6 practice of health care professionals and for identi-
7 fying and notifying outliers.

8 (4) CRITERIA FOR ENTITIES CONDUCTING
9 QUALITY REVIEWS.—The Center shall develop min-
10 imum criteria for competence for entities that can
11 qualify to conduct ongoing and continuous external
12 quality reviews in the administrative regions. Such
13 criteria shall require such an entity to be adminis-
14 tratively independent of the individual or board that
15 administers the region and shall ensure that such
16 entities do not provide financial incentives to review-
17 ers to favor one pattern of practice over another.
18 The Center shall ensure coordination and reporting
19 by such entities to ensure national consistency in
20 quality standards.

21 (5) REPORTING.—The Center shall report to
22 the Secretary annually specifically on findings from
23 outcomes research and development of practice
24 guidelines that may affect the Secretary's deter-

1 mination of coverage of services under section
2 401(a)(1)(G).

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

4 (a) EVALUATING DATA COLLECTION AP-
5 PROACHES.—The Center shall evaluate approaches for the
6 collection of data under this Act, to be performed in con-
7 junction with existing quality reporting requirements and
8 programs under this Act, that allow for the ongoing, accu-
9 rate, and timely collection of data on disparities in health
10 care services and performance on the basis of race, eth-
11 nicity, gender, geography, or socioeconomic status. In con-
12 ducting such evaluation, the Secretary shall consider the
13 following objectives:

14 (1) Protecting patient privacy.

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

18 (3) Improving Universal Medicare Program
19 data on race, ethnicity, gender, geography, and so-
20 cioeconomic status.

21 (b) REPORTS TO CONGRESS.—

22 (1) REPORT ON EVALUATION.—Not later than
23 18 months after the date on which benefits first be-
24 come available as described in section 106(a), the
25 Center shall submit to Congress and the Secretary

1 a report on the evaluation conducted under sub-
2 section (a). Such report shall, taking into consider-
3 ation the results of such evaluation—

4 (A) identify approaches (including defining
5 methodologies) for identifying and collecting
6 and evaluating data on health care disparities
7 on the basis of race, ethnicity, gender, geog-
8 raphy, or socioeconomic status under the Uni-
9 versal Medicare Program; and

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

15 (2) REPORT ON DATA ANALYSES.—Not later
16 than 4 years after the submission of the report
17 under subsection (b)(1), and 4 years thereafter, the
18 Center shall submit to Congress and the Secretary
19 a report that includes recommendations for improv-
20 ing the identification of health care disparities based
21 on the analyses of data collected under subsection
22 (c).

23 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
24 later than 2 years after the date on which benefits first
25 become available as described in section 106(a), the Sec-

1 retary shall implement the approaches identified in the re-
 2 port submitted under subsection (b)(1) for the ongoing,
 3 accurate, and timely collection and evaluation of data on
 4 health care disparities on the basis of race, ethnicity, gen-
 5 der, geography, or socioeconomic status.

6 **TITLE VI—HEALTH BUDGET;**
 7 **PAYMENTS; COST CONTAIN-**
 8 **MENT MEASURES**
 9 **Subtitle A—Budgeting**

10 **SEC. 601. NATIONAL HEALTH BUDGET.**

11 (a) NATIONAL HEALTH BUDGET.—

12 (1) IN GENERAL.—By not later than September
 13 1 of each year, beginning with the year prior to the
 14 date on which benefits first become available as de-
 15 scribed in section 106(a), the Secretary shall estab-
 16 lish a national health budget, which specifies the
 17 total expenditures to be made for covered health
 18 care services under this Act.

19 (2) DIVISION OF BUDGET INTO COMPONENTS.—

20 In addition to the cost of covered health services, the
 21 national health budget shall consist of at least the
 22 following components:

23 (A) Quality assessment activities under
 24 title V.

1 (B) Health professional education expendi-
 2 tures.

3 (C) Administrative costs.

4 (D) Innovation, including in accordance
 5 with section 1115A of the Social Security Act
 6 (42 U.S.C. 1315a).

7 (E) Operating and other expenditures not
 8 described in subparagraphs (A) through (D)
 9 (referred to in this Act as the “operating com-
 10 ponent”), consisting of amounts not included in
 11 the other components.

12 (F) Capital expenditures.

13 (G) Prevention and public health activities.

14 (3) ALLOCATION AMONG COMPONENTS.—The
 15 Secretary shall allocate the budget among the com-
 16 ponents in a manner that—

17 (A) ensures a fair allocation for quality as-
 18 sessment activities; and

19 (B) ensures that the health professional
 20 education expenditure component is sufficient
 21 to provide for the amount of health professional
 22 education expenditures sufficient to meet the
 23 need for covered health care services.

24 (4) TEMPORARY WORKER ASSISTANCE.—For up
 25 to 5 years following the date on which benefits first

1 become available as described in section 106(a), up
2 to 1 percent of the budget may be allocated to pro-
3 grams providing assistance to workers who perform
4 functions in the administration of the health insur-
5 ance system and who may experience economic dis-
6 location as a result of the implementation of this
7 Act.

8 (5) RESERVE FUND.—The Secretary shall es-
9 tablish and maintain a reserve fund to respond to
10 the costs of treating an epidemic, pandemic, natural
11 disaster, or other such health emergency.

12 (b) DEFINITIONS.—In this section:

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

18 (2) HEALTH PROFESSIONAL EDUCATION EX-
19 PENDITURES.—The term “health professional edu-
20 cation expenditures” means expenditures in hospitals
21 and other health care facilities to cover costs associ-
22 ated with teaching and related research activities.

1 **Subtitle B—Payments to Providers**

2 **SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL** 3 **PROVIDERS.**

4 (a) APPLICATION OF PAYMENT PROCESSES UNDER
5 TITLE XVIII.—Except as otherwise provided in this sec-
6 tion, the Secretary shall establish, by regulation, fee
7 schedules that establish payment amounts for benefits
8 under this Act in a manner that is consistent with proc-
9 esses for determining payments for items and services
10 under title XVIII of the Social Security Act (42 U.S.C.
11 1395 et seq.), including the application of the provisions
12 of, and amendments made by, section 612.

13 (b) APPLICATION OF CURRENT AND PLANNED PAY-
14 MENT REFORMS.—Any payment reform activities or dem-
15 onstrations planned or implemented with respect to such
16 title XVIII as of the date of the enactment of this Act
17 shall apply to benefits under this Act, including any re-
18 form activities or demonstrations planned or implemented
19 under the provisions of, or amendments made by, the
20 Medicare Access and CHIP Reauthorization Act of 2015
21 (Public Law 114–10) and the Patient Protection and Af-
22 fordable Care Act (Public Law 111–148).

1 **SEC. 612. ENSURING ACCURATE VALUATION OF SERVICES**
 2 **UNDER THE MEDICARE PHYSICIAN FEE**
 3 **SCHEDULE.**

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

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

10 “(i) IN GENERAL.—Not later than one
 11 year after the date of enactment of this
 12 subparagraph, the Secretary shall estab-
 13 lish, document, and make publicly available
 14 a standardized process for reviewing the
 15 relative values of physicians’ services under
 16 this paragraph.

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

25 (b) PLANNED AND DOCUMENTED USE OF FUNDS.—
 26 Section 1848(c)(2)(M) of the Social Security Act (42

1 U.S.C. 1305w-4(c)(2)(M)) is amended by adding at the
 2 end the following new clause:

3 “(x) PLANNED AND DOCUMENTED
 4 USE OF FUNDS.—For each fiscal year (be-
 5 ginning with the first fiscal year beginning
 6 on or after the date of enactment of this
 7 clause), the Secretary shall provide to Con-
 8 gress a written plan for using the funds
 9 provided under clause (ix) to collect and
 10 use information on physicians’ services in
 11 the determination of relative values under
 12 this subparagraph.”.

13 (c) INTERNAL TRACKING OF REVIEWS.—

14 (1) IN GENERAL.—Not later than one year
 15 after the date of enactment of this Act, the Sec-
 16 retary shall submit to Congress a proposed plan for
 17 systematically and internally tracking its review of
 18 the relative values of physicians’ services, such as by
 19 establishing an internal database, under section
 20 1848(c)(2) of the Social Security Act (42 U.S.C.
 21 1395w-4(c)(2)), as amended by this section.

22 (2) MINIMUM REQUIREMENTS.—The proposal
 23 shall include, at a minimum, plans and a timeline
 24 for achieving the ability to systematically and inter-
 25 nally track the following:

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

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

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

7 (D) When relative values are adjusted.

8 (E) The rationale for final relative value
9 decisions.

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

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

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

17 (e) CONSULTATION WITH MEDICARE PAYMENT AD-
18 VISORY COMMISSION.—

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

22 (A) in subparagraph (B)(i), by inserting
23 “in consultation with the Medicare Payment
24 Advisory Commission,” after “The Secretary,”;
25 and

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

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

8 (A) in subsection (b)(1)(A), by inserting
 9 the following before the semicolon at the end:
 10 “and including coordinating with the Secretary
 11 in accordance with section 1848(c)(2) to sys-
 12 tematically review the relative values established
 13 for physicians’ services, identify potentially
 14 misvalued services, and propose adjustments to
 15 the relative values for physicians’ services”; and

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

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

24 “(Q) PERIODIC AUDIT BY THE COMP-
 25 TROLLER GENERAL.—

1 “(i) IN GENERAL.—The Comptroller
 2 General of the United States (in this sub-
 3 paragraph referred to as the ‘Comptroller
 4 General’) shall periodically audit the review
 5 by the Secretary of relative values estab-
 6 lished under this paragraph for physicians’
 7 services.

8 “(ii) ACCESS TO INFORMATION.—The
 9 Comptroller General shall have unre-
 10 stricted access to all deliberations, records,
 11 and nonproprietary data related to the ac-
 12 tivities carried out under this paragraph,
 13 in a timely manner, upon request.”.

14 **SEC. 613. OFFICE OF PRIMARY HEALTH CARE.**

15 (a) IN GENERAL.—There is established within the
 16 Agency for Healthcare Research and Quality an Office of
 17 Primary Health Care, responsible for coordinating with
 18 the Secretary, the Health Resources and Services Admin-
 19 istration, and other offices in the Department as nec-
 20 essary, in order to—

21 (1) coordinate health professional education
 22 policies and goals, in consultation with the Secretary
 23 to achieve the national goals specified in subsection
 24 (b);

1 (2) develop and maintain a system to monitor
 2 the number and specialties of individuals through
 3 their health professional education, any postgraduate
 4 training, and professional practice;

5 (3) develop, coordinate, and promote policies
 6 that expand the number of primary care practi-
 7 tioners, registered nurses, midlevel practitioners, and
 8 dentists; and

9 (4) recommend the appropriate training, edu-
 10 cation, technical assistance, and patient advocacy en-
 11 hancements of primary care health professionals, in-
 12 cluding registered nurses, to achieve uniform high-
 13 quality and patient safety.

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

19 **SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
 20 **PROVED DEVICES AND EQUIPMENT.**

21 (a) NEGOTIATED PRICES.—The prices to be paid for
 22 covered pharmaceuticals, medical supplies, and medically
 23 necessary assistive equipment shall be negotiated annually
 24 by the Secretary.

25 (b) PRESCRIPTION DRUG FORMULARY.—

1 (1) IN GENERAL.—The Secretary shall establish
 2 a prescription drug formulary system, which shall
 3 encourage best-practices in prescribing and discour-
 4 age the use of ineffective, dangerous, or excessively
 5 costly medications when better alternatives are avail-
 6 able.

7 (2) PROMOTION OF USE OF GENERICS.—The
 8 formulary under this subsection shall promote the
 9 use of generic medications to the greatest extent
 10 possible.

11 (3) FORMULARY UPDATES AND PETITION
 12 RIGHTS.—The formulary under this subsection shall
 13 be updated frequently and clinicians and patients
 14 may petition the Secretary to add new pharma-
 15 ceuticals or to remove ineffective or dangerous medi-
 16 cations from the formulary.

17 (4) USE OF OFF-FORMULARY MEDICATIONS.—
 18 The Secretary shall promulgate rules regarding the
 19 use of off-formulary medications which allow for pa-
 20 tient access but do not compromise the formulary.

21 **TITLE VII—UNIVERSAL** 22 **MEDICARE TRUST FUND**

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

24 (a) IN GENERAL.—There is hereby created on the
 25 books of the Treasury of the United States a trust fund

1 to be known as the Universal Medicare Trust Fund (in
2 this section referred to as the “Trust Fund”). The Trust
3 Fund shall consist of such gifts and bequests as may be
4 made and such amounts as may be deposited in, or appro-
5 priated to, such Trust Fund as provided in this Act.

6 (b) APPROPRIATIONS INTO TRUST FUND.—

7 (1) TAXES.—There are hereby appropriated to
8 the Trust Fund for each fiscal year beginning with
9 the fiscal year which includes the date on which ben-
10 efits first become available as described in section
11 106, out of any moneys in the Treasury not other-
12 wise appropriated, amounts equivalent to 100 per-
13 cent of the net increase in revenues to the Treasury
14 which is attributable to the amendments made by
15 sections 801 and 902. The amounts appropriated by
16 the preceding sentence shall be transferred from
17 time to time (but not less frequently than monthly)
18 from the general fund in the Treasury to the Trust
19 Fund, such amounts to be determined on the basis
20 of estimates by the Secretary of the Treasury of the
21 taxes paid to or deposited into the Treasury; and
22 proper adjustments shall be made in amounts subse-
23 quently transferred to the extent prior estimates
24 were in excess of or were less than the amounts that
25 should have been so transferred.

1 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
2 standing any other provision of law, there are hereby
3 appropriated to the Trust Fund for each fiscal year,
4 beginning with the first fiscal year beginning on or
5 after the effective date of benefits under section 106,
6 the amounts that would otherwise have been appro-
7 priated to carry out the following programs:

8 (A) The Medicare program under title
9 XVIII of the Social Security Act (other than
10 amounts attributable to any premiums under
11 such title).

12 (B) The Medicaid program, under State
13 plans approved under title XIX of such Act.

14 (C) The Federal employees health benefit
15 program, under chapter 89 of title 5, United
16 States Code.

17 (D) The TRICARE program, under chap-
18 ter 55 of title 10, United States Code.

19 (E) The maternal and child health pro-
20 gram (under title V of the Social Security Act),
21 vocational rehabilitation programs, programs
22 for drug abuse and mental health services
23 under the Public Health Service Act, programs
24 providing general hospital or medical assistance,
25 and any other Federal program identified by

1 the Secretary, in consultation with the Sec-
 2 retary of the Treasury, to the extent the pro-
 3 grams provide for payment for health services
 4 the payment of which may be made under this
 5 Act.

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

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

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

1 nished under title XVIII of such Act have been completed,
 2 shall be transferred into the Universal Medicare Trust
 3 Fund under this section.

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

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

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

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

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

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

1 tion services furnished in a State shall reimburse the Uni-
 2 versal Medicare 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 Universal Medi-
 3 care 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. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
 8 **MENTS UNDER ERISA AND CERTAIN OTHER**
 9 **REQUIREMENTS RELATING TO GROUP**
 10 **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.) is repealed.

14 (b) CONFORMING AMENDMENTS.—

15 (1) Section 502(a) of such Act (29 U.S.C.
 16 1132(a)) is amended—

17 (A) by striking paragraph (7); and

18 (B) by redesignating paragraphs (8), (9),
 19 and (10) as paragraphs (7), (8), and (9), re-
 20 spectively.

21 (2) Section 502(c)(1) of such Act (29 U.S.C.
 22 1132(c)(1)) is amended by striking “paragraph (1)
 23 or (4) of section 606,”.

1 (3) Section 514(b) of such Act (29 U.S.C.
2 1144(b)) is amended—

3 (A) in paragraph (7), by striking “section
4 206(d)(3)(B)(i).”; and

5 (B) by striking paragraph (8).

6 (4) The table of contents in section 1 of the
7 Employee Retirement Income Security Act of 1974
8 is amended by striking the items relating to part 6
9 of subtitle B of title I of such Act.

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

11 The amendments made by this title shall take effect
12 on effective date of benefits under section 106(a).

13 **TITLE IX—ADDITIONAL**
14 **CONFORMING AMENDMENTS**

15 **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**
16 **PROGRAMS.**

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

19 (1) IN GENERAL.—Notwithstanding any other
20 provision of law, subject to paragraphs (2) and
21 (3)—

22 (A) no benefits shall be available under
23 title XVIII of the Social Security Act for any
24 item or service furnished beginning on or after

1 the effective date of benefits under section
2 106(a);

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

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

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

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

1 ices shall provide for continuation of benefits under
2 such title or plan until the end of the period of stay.

3 (3) SERVICES UNDER MEDICAID.—

4 (A) IN GENERAL.—This subsection shall
5 not apply to entitlement to medical assistance
6 provided under title XIX of the Social Security
7 Act for—

8 (i) institutional long-term care serv-
9 ices (as defined in section 1947(b) of such
10 Act); or

11 (ii) any other service for which bene-
12 fits are not available under this Act and
13 which is furnished under a State plan
14 under title XIX of the Social Security Act
15 which provided for medical assistance for
16 such service on January 1, 2019.

17 (B) COORDINATION BETWEEN SECRETARY
18 AND STATES.—The Secretary shall coordinate
19 with the directors of State agencies responsible
20 for administering State plans under title XIX
21 of the Social Security Act to—

22 (i) identify services described in sub-
23 paragraph (A)(ii) with respect to each
24 State plan; and

1 (ii) ensure that such services continue
2 to be made available under such plan.

3 (C) MAINTENANCE OF EFFORT REQUIRE-
4 MENT.—With respect to any service described
5 in subparagraph (A)(ii) that is made available
6 under a State plan under title XIX of the So-
7 cial Security Act, the maintenance of effort re-
8 quirements described in section 1947(c) of such
9 Act (related to eligibility standards and re-
10 quired expenditures) shall apply to such service
11 in the same manner that such requirements
12 apply to institutional long-term care services (as
13 defined in section 1947(b) of such Act).

14 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
15 GRAM.—No benefits shall be made available under chapter
16 89 of title 5, United States Code, for any part of a cov-
17 erage period occurring on or after the effective date.

18 (c) TRICARE.—No benefits shall be made available
19 under sections 1079 and 1086 of title 10, United States
20 Code, for items or services furnished on or after the effec-
21 tive date.

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

24 (1) IN GENERAL.—Nothing in this Act shall af-
25 fect the eligibility of veterans for the medical bene-

1 fits and services provided under title 38, United
 2 States Code, or of Indians for the medical benefits
 3 and services provided by or through the Indian
 4 Health Service.

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

8 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**
 9 **EXCHANGES.**

10 Effective on the date described in section 106, the
 11 Federal and State Exchanges established pursuant to title
 12 I of the Patient Protection and Affordable Care Act (Pub-
 13 lic Law 111–148) shall terminate, and any other provision
 14 of law that relies upon participation in or enrollment
 15 through such an Exchange, including such provisions of
 16 the Internal Revenue Code of 1986, shall cease to have
 17 force or effect.

18 **TITLE X—TRANSITION**
 19 **Subtitle A—Transitional Medicare**
 20 **Buy-In Option and Transitional**
 21 **Public Option**

22 **SEC. 1001. LOWERING THE MEDICARE AGE.**

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

1 “TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN
 2 INDIVIDUALS

3 “SEC. 1899C. (a) OPTION.—

4 “(1) IN GENERAL.—Every individual who meets
 5 the requirements described in paragraph (3) shall be
 6 eligible to enroll under this section.

7 “(2) PART A, B, AND D BENEFITS.—An indi-
 8 vidual enrolled under this section is entitled to the
 9 same benefits (and shall receive the same protec-
 10 tions) under this title as an individual who is enti-
 11 tled to benefits under part A and enrolled under
 12 parts B and D, including the ability to enroll in a
 13 Medicare Advantage plan that provides qualified pre-
 14 scription drug coverage (an MA–PD plan).

15 “(3) REQUIREMENTS FOR ELIGIBILITY.—The
 16 requirements described in this paragraph are the fol-
 17 lowing:

18 “(A) The individual is a resident of the
 19 United States.

20 “(B) The individual is—

21 “(i) a citizen or national of the United
 22 States; or

23 “(ii) an alien lawfully admitted for
 24 permanent residence.

1 “(C) The individual is not otherwise enti-
 2 tled to benefits under part A or eligible to en-
 3 roll under part A or part B.

4 “(D) The individual has attained the appli-
 5 cable years of age but has not attained 65 years
 6 of age.

7 “(4) APPLICABLE YEARS OF AGE DEFINED.—
 8 For purposes of this section, the term ‘applicable
 9 years of age’ means—

10 “(A) effective January 1 of the first year
 11 following the date of enactment of the Medicare
 12 for All Act of 2019, the age of 55;

13 “(B) effective January 1 of the second
 14 year following such date of enactment, the age
 15 of 45; and

16 “(C) effective January 1 of the third year
 17 following such date of enactment, the age of 35.

18 “(b) ENROLLMENT; COVERAGE.—The Secretary shall
 19 establish enrollment periods and coverage under this sec-
 20 tion consistent with the principles for establishment of en-
 21 rollment periods and coverage for individuals under other
 22 provisions of this title. The Secretary shall establish such
 23 periods so that coverage under this section shall first begin
 24 on January 1 of the year on which an individual first be-
 25 comes eligible to enroll under this section.

1 “(c) PREMIUM.—

2 “(1) AMOUNT OF MONTHLY PREMIUMS.—The
 3 Secretary shall, during September of each year (be-
 4 ginning with the first September following the date
 5 of enactment of the Medicare for All Act of 2019),
 6 determine a monthly premium for all individuals en-
 7 rolled under this section. Such monthly premium
 8 shall be equal to $\frac{1}{12}$ of the annual premium com-
 9 puted under paragraph (2)(B), which shall apply
 10 with respect to coverage provided under this section
 11 for any month in the succeeding year.

12 “(2) ANNUAL PREMIUM.—

13 “(A) COMBINED PER CAPITA AVERAGE FOR
 14 ALL MEDICARE BENEFITS.—The Secretary shall
 15 estimate the average, annual per capita amount
 16 for benefits and administrative expenses that
 17 will be payable under parts A, B, and D (in-
 18 cluding, as applicable, under part C) in the year
 19 for all individuals enrolled under this section.

20 “(B) ANNUAL PREMIUM.—The annual pre-
 21 mium under this subsection for months in a
 22 year is equal to the average, annual per capita
 23 amount estimated under subparagraph (A) for
 24 the year.

1 “(3) INCREASED PREMIUM FOR CERTAIN PART
 2 C AND D PLANS.—Nothing in this section shall pre-
 3 clude an individual from choosing a Medicare Advan-
 4 tage plan or a prescription drug plan which requires
 5 the individual to pay an additional amount (because
 6 of supplemental benefits or because it is a more ex-
 7 pensive plan). In such case the individual would be
 8 responsible for the increased monthly premium.

9 “(d) PAYMENT OF PREMIUMS.—

10 “(1) IN GENERAL.—Premiums for enrollment
 11 under this section shall be paid to the Secretary at
 12 such times, and in such manner, as the Secretary
 13 determines appropriate.

14 “(2) DEPOSIT.—Amounts collected by the Sec-
 15 retary under this section shall be deposited in the
 16 Federal Hospital Insurance Trust Fund and the
 17 Federal Supplementary Medical Insurance Trust
 18 Fund (including the Medicare Prescription Drug Ac-
 19 count within such Trust Fund) in such proportion
 20 as the Secretary determines appropriate.

21 “(e) NOT ELIGIBLE FOR MEDICARE COST-SHARING
 22 ASSISTANCE.—An individual enrolled under this section
 23 shall not be treated as enrolled under any part of this title
 24 for purposes of obtaining medical assistance for Medicare
 25 cost-sharing or otherwise under title XIX.

1 “(f) TREATMENT IN RELATION TO THE AFFORDABLE
2 CARE ACT.—

3 “(1) SATISFACTION OF INDIVIDUAL MAN-
4 DATE.—For purposes of applying section 5000A of
5 the Internal Revenue Code of 1986, the coverage
6 provided under this section constitutes minimum es-
7 sential coverage under subsection (f)(1)(A)(i) of
8 such section 5000A.

9 “(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—
10 Coverage provided under this section—

11 “(A) shall be treated as coverage under a
12 qualified health plan in the individual market
13 enrolled in through the Exchange where the in-
14 dividual resides for all purposes of section 36B
15 of the Internal Revenue Code of 1986 other
16 than subsection (c)(2)(B) thereof; and

17 “(B) shall not be treated as eligibility for
18 other minimum essential coverage for purposes
19 of subsection (c)(2)(B) of such section 36B.

20 The Secretary shall determine the applicable second
21 lowest cost silver plan which shall apply to coverage
22 under this section for purposes of section 36B of
23 such Code.

24 “(3) ELIGIBILITY FOR COST-SHARING SUB-
25 SIDIES.—For purposes of applying section 1402 of

1 the Patient Protection and Affordable Care Act (42
2 U.S.C. 18071)—

3 “(A) coverage provided under this section
4 shall be treated as coverage under a qualified
5 health plan in the silver level of coverage in the
6 individual market offered through an Exchange;
7 and

8 “(B) the Secretary shall be treated as the
9 issuer of such plan.

10 “(g) NO EFFECT ON BENEFITS FOR INDIVIDUALS
11 OTHERWISE ELIGIBLE OR ON TRUST FUNDS.—The Sec-
12 retary shall implement the provisions of this section in
13 such a manner to ensure that such provisions—

14 “(1) have no effect on the benefits under this
15 title for individuals who are entitled to, or enrolled
16 for, such benefits other than through this section;
17 and

18 “(2) have no negative impact on the Federal
19 Hospital Insurance Trust Fund or the Federal Sup-
20plementary Medical Insurance Trust Fund (includ-
21ing the Medicare Prescription Drug Account within
22such Trust Fund).

23 “(h) CONSULTATION.—In promulgating regulations
24 to implement this section, the Secretary shall consult with
25 interested parties, including groups representing bene-

1 ficiaries, health care providers, employers, and insurance
 2 companies.”.

3 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**
 4 **TION PLAN.**

5 (a) IN GENERAL.—To carry out the purpose of this
 6 section, for plan years beginning with the first plan year
 7 that begins after the date of enactment of this Act and
 8 ending with the effective date described in section 106,
 9 the Secretary, acting through the Administrator of the
 10 Centers for Medicare & Medicaid (referred to in this sec-
 11 tion as the “Administrator”), shall establish, and provide
 12 for the offering through the Exchanges, of a public health
 13 plan (in this Act referred to as the “Medicare Transition
 14 plan”) that provides affordable, high-quality health bene-
 15 fits coverage throughout the United States.

16 (b) ADMINISTERING THE MEDICARE TRANSI-
 17 TION.—

18 (1) ADMINISTRATOR.—The Administrator shall
 19 administer the Medicare Transition plan in accord-
 20 ance with this section.

21 (2) APPLICATION OF ACA REQUIREMENTS.—
 22 Consistent with this section, the Medicare Transition
 23 plan shall comply with requirements under title I of
 24 the Patient Protection and Affordable Care Act (and
 25 the amendments made by that title) and title XXVII

1 of the Public Health Service Act (42 U.S.C. 300gg
 2 et seq.) that are applicable to qualified health plans
 3 offered through the Exchanges, subject to the limita-
 4 tion under subsection (e)(2).

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

13 (4) ELIGIBILITY TO PURCHASE.—Any United
 14 States resident may enroll in the Medicare Transi-
 15 tion plan.

16 (c) BENEFITS; ACTUARIAL VALUE.—In carrying out
 17 this section, the Administrator shall ensure that the Medi-
 18 care Transition plan provides—

19 (1) coverage for the benefits required to be cov-
 20 ered under title II; and

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

24 (d) PROVIDERS AND REIMBURSEMENT RATES.—

1 (1) IN GENERAL.—With respect to the reim-
2 bursement provided to health care providers for cov-
3 ered benefits, as described in section 201, provided
4 under the Medicare Transition plan, the Adminis-
5 trator shall reimburse such providers at rates deter-
6 mined for equivalent items and services under the
7 original Medicare fee-for-service program under
8 parts A and B of title XVIII of the Social Security
9 Act (42 U.S.C. 1395c et seq.). For items and serv-
10 ices covered under the Medicare Transition plan but
11 not covered under such parts A and B, the Adminis-
12 trator shall reimburse providers at rates set by the
13 Administrator in a manner consistent with the man-
14 ner in which rates for other items and services were
15 set under the original Medicare fee-for-service pro-
16 gram.

17 (2) PRESCRIPTION DRUGS.—Any payment rate
18 under this subsection for a prescription drug shall be
19 at a rate negotiated by the Administrator with the
20 manufacturer of the drug. If the Administrator is
21 unable to reach a negotiated agreement on such a
22 reimbursement rate, the Administrator shall estab-
23 lish the rate at an amount equal to the lesser of—

24 (A) the price paid by the Secretary of Vet-
25 erans Affairs to procure the drug under the

1 laws administered by the Secretary of Veterans
2 Affairs;

3 (B) the price paid to procure the drug
4 under section 8126 of title 38, United States
5 Code; or

6 (C) the best price determined under sec-
7 tion 1927(c)(1)(C) of the Social Security Act
8 (42 U.S.C. 1396r-8(c)(1)(C)) for the drug.

9 (3) PARTICIPATING PROVIDERS.—

10 (A) IN GENERAL.—A health care provider
11 that is a participating provider of services or
12 supplier under the Medicare program under
13 title XVIII of the Social Security Act (42
14 U.S.C. 1395 et seq.) or under a State Medicaid
15 plan under title XIX of such Act (42 U.S.C.
16 1396 et seq.) on the date of enactment of this
17 Act shall be a participating provider in the
18 Medicare Transition plan.

19 (B) ADDITIONAL PROVIDERS.—The Ad-
20 ministrator shall establish a process to allow
21 health care providers not described in subpara-
22 graph (A) to become participating providers in
23 the Medicare Transition plan. Such process
24 shall be similar to the process applied to new
25 providers under the Medicare program.

1 (e) PREMIUMS.—

2 (1) DETERMINATION.—The Administrator shall
3 determine the premium amount for enrolling in the
4 Medicare Transition plan, which—

5 (A) may vary according to family or indi-
6 vidual coverage, age, and tobacco status (con-
7 sistent with clauses (i), (iii), and (iv) of section
8 2701(a)(1)(A) of the Public Health Service Act
9 (42 U.S.C. 300gg(a)(1)(A))); and

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

17 (2) LIMITATION.—Variation in premium rates
18 of the Medicare Transition plan by rating area, as
19 described in clause (ii) of section 2701(a)(1)(A)(iii)
20 of the Public Health Service Act (42 U.S.C.
21 300gg(a)(1)(A)) is not permitted.

22 (f) TERMINATION.—This section shall cease to have
23 force or effect on the effective date described in section
24 106.

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

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION PLAN ENROLLEES AT OR ABOVE 44 PERCENT OF POVERTY IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) SPECIAL RULES FOR MEDICARE TRANSITION PLAN ENROLLEES.—

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

“(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for

1 All Act of 2019) does not provide for eligi-
 2 bility under clause (i)(VIII) or (ii)(XX) of
 3 section 1902(a)(10)(A) of the Social Secu-
 4 rity Act for medical assistance under title
 5 XIX of such Act (or a waiver of the State
 6 plan approved under section 1115) who is
 7 covered, or whose spouse or dependent (as
 8 defined in section 152) is covered, by the
 9 Medicare Transition plan established under
 10 section 1002(a) of the Medicare for All Act
 11 of 2019 for all months in the taxable year,
 12 subparagraphs (A) and (B) shall be ap-
 13 plied by substituting ‘0 percent’ for ‘100
 14 percent’ each place it appears.”.

15 (B) PREMIUM ASSISTANCE AMOUNTS FOR
 16 TAXPAYERS ENROLLED IN MEDICARE TRANSI-
 17 TION PLAN.—

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

21 (I) by redesignating clause (ii) as
 22 clause (iii);

23 (II) by striking “clause (ii)” in
 24 clause (i) and inserting “clauses (ii)
 25 and (iii)”; and

1 (III) by inserting after clause (i)
2 the following new clause:
3 “(ii) SPECIAL RULES FOR TAXPAYERS
4 ENROLLED IN MEDICARE TRANSITION
5 PLAN.—In the case of a taxpayer who is
6 covered, or whose spouse or dependent (as
7 defined in section 152) is covered, by the
8 Medicare Transition plan established under
9 section 1002(a) of the Medicare for All Act
10 of 2019 for all months in the taxable year,
11 the applicable percentage for any taxable
12 year shall be determined in the same man-
13 ner as under clause (i), except that the fol-
14 lowing table shall apply in lieu of the table
15 contained in such clause:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent	2	2
100 percent up to 138 percent	2.04	2.04
138 percent up to 150 percent	3.06	4.08
150 percent and above	4.08	5”.

16 (ii) CONFORMING AMENDMENT.—Sub-
17 clause (I) of clause (iii) of section
18 36B(b)(3) of such Code, as redesignated
19 by subparagraph (A)(i), is amended by in-
20 serting “, and determined after the appli-

1 cation of clause (ii)” after “after applica-
 2 tion of this clause”.

3 (2) COST-SHARING SUBSIDIES.—Subsection (b)
 4 of section 1402 of the Patient Protection and Af-
 5 fordable Care Act (42 U.S.C. 18071(b)) is amend-
 6 ed—

7 (A) by inserting “, or in the Medicare
 8 Transition plan established under section
 9 1002(a) of the Medicare for All Act of 2019,”
 10 after “coverage” in paragraph (1);

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

15 (C) by striking “INSURED.—In this sec-
 16 tion” and inserting “INSURED.—
 17 “(1) IN GENERAL.—In this section”;

18 (D) by striking the flush language; and

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

21 “(2) SPECIAL RULES.—

22 “(A) INDIVIDUALS LAWFULLY PRESENT.—
 23 In the case of an individual described in section
 24 36B(c)(1)(B) of the Internal Revenue Code of
 25 1986, the individual shall be treated as having

1 household income equal to 100 percent of the
 2 poverty line for a family of the size involved for
 3 purposes of applying this section.

4 “(B) MEDICARE TRANSITION PLAN EN-
 5 ROLLEES IN MEDICAID NON-EXPANSION
 6 STATES.—In the case of an individual residing
 7 in a State which (as of the date of the enact-
 8 ment of the Medicare for All Act of 2019) does
 9 not provide for eligibility under clause (i)(VIII)
 10 or (ii)(XX) of section 1902(a)(10)(A) of the So-
 11 cial Security Act for medical assistance under
 12 title XIX of such Act (or a waiver of the State
 13 plan approved under section 1115) who enrolls
 14 in such Medicare Transition plan, the preceding
 15 sentence, paragraph (1)(B), and paragraphs
 16 (1)(A)(i) and (2)(A) of subsection (c) shall each
 17 be applied by substituting ‘0 percent’ for ‘100
 18 percent’ each place it appears.

19 “(C) ADJUSTED COST-SHARING FOR MEDI-
 20 CARE TRANSITION PLAN ENROLLEES.—In the
 21 case of any individual who enrolls in such Medi-
 22 care Transition plan, in lieu of the percentages
 23 under subsection (c)(1)(B)(i) and (c)(2), the
 24 Secretary shall prescribe a method of deter-
 25 mining the cost-sharing reduction for any such

individual such that the total of the cost-sharing and the premiums paid by the individual under such Medicare Transition plan does not exceed the percentage of the total allowed costs of benefits provided under the plan equal to the final premium percentage applicable to such individual under section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986.”.

(h) CONFORMING AMENDMENTS.—

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

(A) in the paragraph heading, by inserting “, THE MEDICARE TRANSITION PLAN,” before “AND”; and

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

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

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

3 **SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-**
 4 **POCKET EXPENDITURES FOR FEE-FOR-SERV-**
 5 **ICE BENEFITS AND ELIMINATION OF PARTS A**
 6 **AND B DEDUCTIBLES.**

7 (a) PROTECTION AGAINST HIGH OUT-OF-POCKET
 8 EXPENDITURES.—Title XVIII of the Social Security Act
 9 (42 U.S.C. 1395 et seq.), as amended by section 1001,
 10 is amended by adding at the end the following new section:

11 “PROTECTION AGAINST HIGH OUT-OF-POCKET
 12 EXPENDITURES

13 “SEC. 1899D. (a) IN GENERAL.—Notwithstanding
 14 any other provision of this title, in the case of an indi-
 15 vidual entitled to, or enrolled for, benefits under part A
 16 or enrolled in part B, if the amount of the out-of-pocket
 17 cost-sharing of such individual for a year (effective the
 18 year beginning January 1 of the year following the date
 19 of enactment of the Medicare for All Act of 2019) equals
 20 or exceeds \$1,500, the individual shall not be responsible
 21 for additional out-of-pocket cost-sharing occurred during
 22 that year.

23 “(b) OUT-OF-POCKET COST-SHARING DEFINED.—

24 “(1) IN GENERAL.—Subject to paragraphs (2)
 25 and (3), in this section, the term ‘out-of-pocket cost-

1 sharing’ means, with respect to an individual, the
 2 amount of the expenses incurred by the individual
 3 that are attributable to—

4 “(A) coinsurance and copayments applica-
 5 ble under part A or B; or

6 “(B) for items and services that would
 7 have otherwise been covered under part A or B
 8 but for the exhaustion of those benefits.

9 “(2) CERTAIN COSTS NOT INCLUDED.—

10 “(A) NON-COVERED ITEMS AND SERV-
 11 ICES.—Expenses incurred for items and serv-
 12 ices which are not included (or treated as being
 13 included) under part A or B shall not be con-
 14 sidered incurred expenses for purposes of deter-
 15 mining out-of-pocket cost-sharing under para-
 16 graph (1).

17 “(B) ITEMS AND SERVICES NOT FUR-
 18 NISHED ON AN ASSIGNMENT-RELATED BASIS.—

19 If an item or service is furnished to an indi-
 20 vidual under this title and is not furnished on
 21 an assignment-related basis, any additional ex-
 22 penses the individual incurs above the amount
 23 the individual would have incurred if the item
 24 or service was furnished on an assignment-re-
 25 lated basis shall not be considered incurred ex-

1 penses for purposes of determining out-of-pocket
2 cost-sharing under paragraph (1).

3 “(3) SOURCE OF PAYMENT.—For purposes of
4 paragraph (1), the Secretary shall consider expenses
5 to be incurred by the individual without regard to
6 whether the individual or another person, including
7 a State program or other third-party coverage, has
8 paid for such expenses.”.

9 (b) ELIMINATION OF PARTS A AND B
10 DEDUCTIBLES.—

11 (1) PART A.—Section 1813(b) of the Social Se-
12 curity Act (42 U.S.C. 1395e(b)) is amended by add-
13 ing at the end the following new paragraph:

14 “(4) For each year (beginning January 1 of the year
15 following the date of enactment of the Medicare for All
16 Act of 2019), the inpatient hospital deductible for the year
17 shall be \$0.”.

18 (2) PART B.—Section 1833(b) of the Social Se-
19 curity Act (42 U.S.C. 1395l(b)) is amended, in the
20 first sentence—

21 (A) by striking “and for a subsequent
22 year” and inserting “for each of 2006 through
23 the year that includes the date of enactment of
24 the Medicare for All Act of 2019”; and

1 (B) by inserting “, and \$0 for each year
2 subsequent year” after “\$1”).

3 **SEC. 1012. REDUCTION IN MEDICARE PART D ANNUAL OUT-**
4 **OF-POCKET THRESHOLD AND ELIMINATION**
5 **OF COST-SHARING ABOVE THAT THRESHOLD.**

6 (a) REDUCTION.—Section 1860D–2(b)(4)(B) of the
7 Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)) is
8 amended—

9 (1) in clause (i), by striking “For purposes”
10 and inserting “Subject to clause (iii), for purposes”;
11 and

12 (2) by adding at the end the following new
13 clause:

14 “(iii) REDUCTION IN THRESHOLD
15 DURING TRANSITION PERIOD.—

16 “(I) IN GENERAL.—Subject to
17 subclause (II), for plan years begin-
18 ning on or after January 1 following
19 the date of enactment of the Medicare
20 for All Act of 2019 and before Janu-
21 ary 1 of the year that is 4 years fol-
22 lowing such date of enactment, not-
23 withstanding clauses (i) and (ii), the
24 ‘annual out-of-pocket threshold’ speci-

1 fied in this subparagraph is equal to
2 \$305.

3 “(II) AUTHORITY TO EXEMPT
4 BRAND-NAME DRUGS IF GENERIC
5 AVAILABLE.—In applying subclause
6 (I), the Secretary may exempt costs
7 incurred for a covered part D drug
8 that is an applicable drug under sec-
9 tion 1860D–14A(g)(2) if the Sec-
10 retary determines that a generic
11 version of that drug is available.”.

12 (b) ELIMINATION OF COST-SHARING.—Section
13 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C.
14 1395w–102(b)(4)(A)) is amended—

15 (1) in clause (i)—

16 (A) by redesignating subclauses (I) and
17 (II) as items (aa) and (bb), respectively;

18 (B) by striking “subparagraph (B), with
19 cost-sharing” and inserting the following: “sub-
20 paragraph (B)—

21 “(I) for plan years 2006 through
22 the plan year ending December 31 fol-
23 lowing the date of enactment of the
24 Medicare for All Act of 2019, with
25 cost-sharing”;

1 (C) in item (bb), as redesignated by sub-
 2 paragraph (A), by striking the period at the
 3 end and inserting “; and”; and

4 (D) by adding at the end the following new
 5 subclause:

6 “(II) for the plan year beginning
 7 January 1 following the date of enact-
 8 ment of the Medicare for All Act of
 9 2019 and the two subsequent plan
 10 years, without any cost-sharing.”; and

11 (2) in clause (ii)—

12 (A) by striking “clause (i)(I)” and insert-
 13 ing “clause (i)(I)(aa)”;

14 (B) by adding at the end the following new
 15 sentence: “The Secretary shall continue to cal-
 16 culate the dollar amounts specified in clause
 17 (i)(I)(aa), including with the adjustment under
 18 this clause, after plan year 2018 for purposes
 19 of 1860D–14(a)(1)(D)(iii).”.

20 (c) CONFORMING AMENDMENTS TO LOW-INCOME
 21 SUBSIDY.—Section 1860D–14(a) of the Social Security
 22 Act (42 U.S.C. 1395w–114(a)) is amended—

23 (1) in paragraph (1)—

1 (A) in subparagraph (D)(iii), by striking
2 “1860D–2(b)(4)(A)(i)(I)” and inserting
3 “1860D–2(b)(4)(A)(i)(I)(aa)”; and

4 (B) in subparagraph (E)—

5 (i) in the heading, by inserting
6 “PRIOR TO THE ELIMINATION OF SUCH
7 COST-SHARING FOR ALL INDIVIDUALS”
8 after “THRESHOLD”; and

9 (ii) by striking “The elimination” and
10 inserting “For plan years 2006 through
11 the plan year ending December 31 fol-
12 lowing the date of enactment of the Medi-
13 care for All Act of 2019, the elimination”;
14 and

15 (2) in paragraph (2)(E)—

16 (A) in the heading, by inserting “PRIOR TO
17 THE ELIMINATION OF SUCH COST-SHARING FOR
18 ALL INDIVIDUALS” after “THRESHOLD”;

19 (B) by striking “Subject to” and inserting
20 “For plan years 2006 through the plan year
21 ending December 31 following the date of en-
22 actment of the Medicare for All Act of 2019,
23 subject to”; and

24 (C) by striking “1860D–2(b)(4)(A)(i)(I)”
25 and inserting “1860D–2(b)(4)(A)(i)(I)(aa)”.

1 **SEC. 1013. COVERAGE OF DENTAL AND VISION SERVICES**
 2 **AND HEARING AIDS AND EXAMINATIONS**
 3 **UNDER MEDICARE PART B.**

4 (a) DENTAL SERVICES.—

5 (1) REMOVAL OF EXCLUSION FROM COV-
 6 ERAGE.—Section 1862(a) of the Social Security Act
 7 (42 U.S.C. 1395y(a)) is amended by striking para-
 8 graph (12).

9 (2) COVERAGE.—

10 (A) IN GENERAL.—Section 1861(s)(2) of
 11 the Social Security Act (42 U.S.C. 1395x(s)(2))
 12 is amended—

13 (i) in subparagraph (GG), by striking
 14 “and” at the end;

15 (ii) in subparagraph (HH), by strik-
 16 ing the period at the end and inserting “;
 17 and”; and

18 (iii) by adding at the end the fol-
 19 lowing new subparagraph:

20 “(II) dental services;”.

21 (B) PAYMENT.—Section 1833(a)(1) of the
 22 Social Security Act (42 U.S.C. 1395l(a)(1)) is
 23 amended—

24 (i) by striking “and” before “(CC)”;
 25 and

1 (ii) by inserting before the semicolon
 2 at the end the following: “, and (DD) with
 3 respect to dental services described in sec-
 4 tion 1861(s)(2)(II), the amount paid shall
 5 be an amount equal to 80 percent of the
 6 lesser of the actual charge for the services
 7 or the amount determined under the fee
 8 schedule established under section
 9 1848(b).”.

10 (C) EFFECTIVE DATE.—The amendments
 11 made by this subsection shall apply to items
 12 and services furnished on or after January 1
 13 following the date of the enactment of this Act.

14 (b) VISION SERVICES.—

15 (1) IN GENERAL.—Section 1861(s)(2) of the
 16 Social Security Act (42 U.S.C. 1395x(s)(2)), as
 17 amended by subsection (a), is amended—

18 (A) in subparagraph (HH), by striking
 19 “and” at the end;

20 (B) in subparagraph (II), by inserting
 21 “and” at the end; and

22 (C) by adding at the end the following new
 23 subparagraph:

24 “(JJ) vision services;”.

(2) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a), is amended—

(A) by striking “and” before “(DD)”;

(B) by inserting before the semicolon at the end the following: “, and (EE) with respect to vision services described in section 1861(s)(2)(JJ), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1 following the date of the enactment of this Act.

(c) HEARING AIDS AND EXAMINATIONS THEREFOR.—

(1) IN GENERAL.—Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by striking “hearing aids or examinations therefor,”.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services

1 furnished on or after January 1 following the date
2 of the enactment of this Act.

3 **SEC. 1014. 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

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

(b) CONFORMING AMENDMENTS.—

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

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

(h); and

(B) redesignating subsections (g) and (i)

as subsections (f) and (g), respectively.

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

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

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

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

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 January 1 of the year that is 4 years after such date of
11 enactment.

12 **SEC. 1015. GUARANTEED ISSUE OF MEDIGAP POLICIES.**

13 Section 1882 of the Social Security Act (42 U.S.C.
14 1395ss) is amended by adding at the end the following
15 new subsection:

16 “(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELI-
17 GIBLE MEDICARE BENEFICIARIES.—Notwithstanding
18 paragraphs (2)(A) and (2)(D) of subsection (s) or any
19 other provision of this section, on or after the date of en-
20 actment of this subsection, the issuer of a medicare sup-
21 plemental policy may not deny or condition the issuance
22 or effectiveness of a medicare supplemental policy, or dis-
23 criminate in the pricing of the policy, because of health
24 status, claims experience, receipt of health care, or medical
25 condition in the case of any individual entitled to, or en-

1 rolled for, benefits under part A and enrolled for benefits
2 under part B.”.

3 **Subtitle C—Private Health Insur-**
4 **ance Availability During Transi-**
5 **tional Period**

6 **SEC. 1021. CONTINUITY OF CARE.**

7 (a) IN GENERAL.—The Secretary shall ensure that
8 all individuals enrolled in, or who seek to enroll in, a group
9 health plan, health insurance coverage offered by a health
10 insurance issuer, or the plan established under section
11 1002 during the transition period of this Act are protected
12 from disruptions in their care during the transition period.

13 (b) PUBLIC CONSULTATION DURING TRANSITION.—
14 The Secretary shall consult with communities and advo-
15 cacy organizations of individuals living with disabilities
16 and other patient advocacy organizations to ensure the
17 transition described in this section takes into account the
18 continuity of care for individuals with disabilities, complex
19 medical needs, or chronic conditions.

20 (c) DEFINITIONS.—In this section, the terms “health
21 insurance coverage”, “health insurance issuer”, and
22 “group health plans” have the meanings given such terms
23 in section 2791 of the Public Health Service Act (42
24 U.S.C. 300gg–91).

1 **TITLE XI—MISCELLANEOUS**

2 **SEC. 1101. UPDATING RESOURCE LIMITS FOR SUPPLE-**
3 **MENTAL SECURITY INCOME ELIGIBILITY**
4 **(SSI).**

5 Section 1611(a)(3) of the Social Security Act (42
6 U.S.C. 1382(a)(3)) is amended—

7 (1) in subparagraph (A)—

8 (A) by striking “and” after “January 1,
9 1988,”; and

10 (B) by inserting “, and to \$6,200 on Janu-
11 ary 1, 2019” before the period;

12 (2) in subparagraph (B)—

13 (A) by striking “and” after “January 1,
14 1988,”; and

15 (B) by inserting “, and to \$4,100 on Janu-
16 ary 1, 2019” before the period; and

17 (3) by adding at the end the following new sub-
18 paragraph:

19 “(C) Beginning with December of 2019, when-
20 ever the dollar amounts in effect under paragraphs
21 (1)(A) and (2)(A) of this subsection are increased
22 for a month by a percentage under section
23 1617(a)(2), each of the dollar amounts in effect
24 under this paragraph shall be increased, effective
25 with such month, by the same percentage (and

1 rounded, if not a multiple of \$10, to the closest mul-
2 tiple of \$10). Each increase under this subparagraph
3 shall be based on the unrounded amount for the
4 prior 12-month period.”.

5 **SEC. 1102. DEFINITIONS.**

6 In this Act—

7 (1) the term “Secretary” means the Secretary
8 of Health and Human Services;

9 (2) the term “State” means a State, the Dis-
10 trict of Columbia, or a territory of the United
11 States; and

12 (3) the term “United States” shall include the
13 States, the District of Columbia, and the territories
14 of the United States.

○