To provide reimbursements for certain costs of health care items and services, including prescription drugs, furnished during the public health emergency declared with respect to COVID–19.

IN THE SENATE OF THE UNITED STATES

Mr. SANDERS introduced the following bill; which was read twice and referred to the Committee on ________________

A BILL

To provide reimbursements for certain costs of health care items and services, including prescription drugs, furnished during the public health emergency declared with respect to COVID–19.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Health Care Emer-

gency Guarantee Act”.

YSD 9C HL4
SEC. 2. REIMBURSEMENTS FOR CERTAIN COSTS OF HEALTH CARE ITEMS AND SERVICES INCLUDING PRESCRIPTION DRUGS FURNISHED DURING PUBLIC HEALTH EMERGENCY.

(a) IN GENERAL.—During the period beginning on the date of enactment of this Act and ending on the date the Secretary certifies to Congress that a vaccine approved by the Food and Drug Administration for COVID–19 is widely available to the public, the Secretary shall make payments to qualified providers with respect to applicable health care items and services as defined in subsection (b) that are furnished to an applicable individual an amount equal to—

(1) in the case of any portion of such period in which an applicable individual is enrolled in a public or private health insurance plan, the amount of any cost-sharing, including any deductibles, copayments, coinsurance or similar charges, that would otherwise be applicable under such plan, including with respect to prescription drug coverage under the plan;

(2) in the case of any portion of such period in which an applicable individual is uninsured, an amount equal to the amount that would be paid to the qualified provider for the same or equivalent items or services, including with respect to any inpatient or physician-administered drugs (and excluding
outpatient prescription drugs or biologicals with re-
respect to which coverage is provided under subsection 
(c)), under the Medicare program under title XVIII 
of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) **APPlicable Health Care Items and Serv-
ces; Applicable Individual Defined.**—In this sec-
tion:

1. **(1) Applicable health care items and**
   services.—The term “applicable health care items 
   and services” means, with respect to an applicable 
   individual, any health care items and services that 
   are medically necessary or appropriate for the main-
   tenance of health or for the diagnosis, treatment, or 
   rehabilitation of a health condition of the applicable 
   individual, including—

   (A) any testing services and treatments for 
   COVID–19 or related complications, including 
   vaccines, diagnostic tests, drugs and biologicals, 
   and therapies; and

   (B) in the case of an applicable individual 
   who is enrolled in a public or private health in-
   surance plan, any health care items and serv-
   ices covered by such plan as of March 1, 2020, 
or in the case of an applicable individual who 
enrolls in such plan after the date, any health
care items and services covered by such plan as
of the date of such enrollment.

(2) APPLICABLE INDIVIDUAL.—The term “ap-
licable individual” means an individual who is a
resident of the United States.

(c) REQUIREMENTS.—

(1) NO EFFECT ON APPLICABLE COST-SHARING
requirements.—Nothing in this section shall af-
fect the application of any requirements applicable
under Federal or State law with respect to coverage
of health care items and services without any cost-
sharing.

(2) MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—During the period de-
scribed in subsection (a), a public or private
health plan shall not increase cost-sharing, de-
crease benefits, or otherwise make coverage less
generous than the benefits offered on the date
of enactment of this Act.

(B) NEW ITEMS AND SERVICES.—During
such period, a public or private health plan
shall provide coverage of new items and serv-
ices, including those related to COVID–19, as
appropriate, at a minimum, at a level consistent
with the prior coverage practices and
formularies of the plan.

(3) LIMITATION ON OUT-OF-POCKET EXPENSES.—During such period, in order to be eligible
to receive payments under this section, a qualified
provider shall agree not to impose on an applicable
individual any charge for applicable health care
items and services furnished to the applicable indi-
vidual.

(4) PERMISSIBLE BILLING OF PLANS; LIMITA-
TION ON BALANCE BILLING.—During such period, in
order to be eligible to receive payments under this
section, a qualified provider shall agree, with respect
to applicable health care items and services fur-
nished to an applicable individual when such indi-
vidual is enrolled in a public or private health insur-
ance plan—

(A) not to impose any charge on the plan
for such items and services beyond the amount
otherwise payable by the plan; and

(B) not to bill the applicable individual for
any amounts in excess of the amount described
in subparagraph (A).

(5) MEDICAL DEBT COLLECTION.—A qualified
provider shall agree—
(A) to immediately halt all medical debt collection, including collection activities carried out by third parties, during such period and shall not collect medical debt or have third parties collect medical debt for applicable health care items and services furnished during such period; and

(B) to refrain from pursuing medical debt collection, including collection activities carried out by third parties, after such period with respect to items and services related to the diagnosis or treatment of COVID–19 (regardless of whether such services were furnished before, during, or after such period) and shall not collect medical debt or have third parties collect medical debt for such items or services after such period.

(6) Submission of bills and documentation.—A qualified provider shall agree to submit bills and any required supporting documentation relating to the provision of applicable health care items and services within 30 days after the date of providing such services, in such manner as the Secretary determines appropriate.
(d) Waiver of Late Enrollment Penalties Under Medicare.—During the period described in subsection (a), no increase in the monthly premium of an individual pursuant to section 1818(c), 1839(b), or 1860D–13 of the Social Security Act (42 U.S.C. 1395i–2(c), 1395r(b), 1395w–113) shall be effected in the case of any individual who enrolls for benefits under title XVIII of such Act with respect to any period prior to the date of such enrollment.

(e) Coverage With Respect to Outpatient Prescription Drugs.—

(1) In general.—During the period described in subsection (a), with respect to outpatient prescription drugs or biologicals described in subsection (b)(1)(A) that are dispensed to uninsured individuals, the Secretary shall establish procedures under which—

(A) such drugs or biologicals are dispensed at no cost to such individuals;

(B) pharmacies that dispense such drugs or biologicals—

(i) are reimbursed by the Secretary for such drugs or biologicals dispensed to such individuals at an amount equal to the price paid by the Secretary of Veterans Af-
fairs to procure the drug or biological
under the laws administered by the Sec-
retary of Veterans Affairs; and

(ii) agree not to charge such individ-
uals for any difference between the amount
reimbursed under clause (i) and the cost to
the pharmacy for the drug; and

(C) manufacturers of such drugs or
biologicals reimburse pharmacies for any dif-
ference described in subparagraph (B)(ii) with
respect to drugs or biologicals of the manufac-
turer that are dispensed to such individuals.

(2) CONDITION OF COVERAGE UNDER MEDI-
care.—During the period described in subsection
(a), no coverage may be provided under part B or
D of title XVIII of the Social Security Act (42
U.S.C. 1395j et seq., 1395w–101 et seq.) with re-
spect to a drug or biological of a manufacturer if the
manufacturer does not enter into an agreement with
the Secretary to carry out the requirements applica-
ble with respect to such manufacturers under this
subsection.

(3) REQUIREMENT FOR PARTICIPATING PHAR-
macies.—During the period described in subsection
(a), a prescription drug plan under part D of title
(a) XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.) may not contract with a pharmacy if the pharmacy does not enter into an agreement with the Secretary to carry out the requirements applicable with respect to pharmacies under this subsection.

(f) OTHER DEFINITIONS.—

(1) PUBLIC OR PRIVATE HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—The term “public or private health insurance plan” means any of the following:

(i) A group health plan, or group health insurance coverage, as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(ii) A qualified health plan, as defined in section 1301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18021).

(iii) Subject to subparagraph (B), any health insurance coverage (other than a plan described in clause (ii)) offered in the individual market, as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).
Service Act, including any short-term limited duration insurance.

(iv) A health plan offered under chapter 89 of title 5, United States Code.

(v) A Federal health care program (as defined under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)), including—

(I) health benefits furnished under the TRICARE program (as defined in section 1072 of title 10, United States Code);

(II) health benefits furnished to veterans under the laws administered by the Secretary of Veterans Affairs;

and

(III) health benefits furnished to Indians (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) receiving health services through the Indian Health Service, including through an Urban Indian Organization, regardless of whether such benefits are for items or services that have been authorized
under the purchased/referred care system funded by the Indian Health Service or are covered as a health service of the Indian Health Service.

(B) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term “public or private health insurance coverage” includes the health insurance coverage described in clause (iii) of subparagraph (A) only with respect to an individual who is enrolled in such coverage on March 1, 2020.

(2) QUALIFIED PROVIDER.—The term “qualified provider” means a health care provider who is a participating provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such term includes a health care provider who is not a participating provider under such program if the health care provider would meet the criteria for such participation and, if the State requires the health care provider to be licensed by the State, is licensed by the State in which the items or services are furnished.

(3) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(g) IMPLEMENTATION.—
(1) **IN GENERAL.**—The Secretary, in coordination with the Secretary of the Treasury, the Commissioner of Social Security, and the Secretary of Labor, shall implement the provisions of this section not later than the date that is 7 days after the date of the enactment of this Act.

(2) **ENSURING TIMELY PAYMENT.**—The Secretary shall establish a process and issue such guidance as is necessary to ensure a qualified provider receives payments under this section in a timely manner.

(3) **ENSURING COLLECTION OF DATA ON DISPARITIES.**—The Secretary shall implement this section in a manner and issue such guidance as is necessary to allow for the ongoing, accurate, and timely collection and analysis of data on disparities in accordance with subsection (h).

(h) **COLLECTION OF DATA ON DISPARITIES.**—

(1) **IN GENERAL.**—During the period described in subsection (a), the Secretary shall collect data on disparities across race, ethnicity, primary language, gender, sexual orientation, disability status, age, geographic area, insurance status, and socioeconomic status—
(A) in health outcomes and access to health care related to the COVID–19 outbreak, including data on COVID–19 cases, treatment, and deaths; and

(B) in patient access to applicable health care items and services under this section.

(2) Public Availability.—The Secretary shall—

(A) make data collected under this subsection publicly available on the internet website of the Department of Health and Human Services as soon as is practicable, but not later than 30 days after the date of enactment of this Act, in a manner that allows researchers, scholars, health care providers, and others to access and analyze such data, without compromising patient privacy; and

(B) update such data on a weekly basis thereafter for the duration of the period described in subsection (a).

(i) Weekly Reports to Congress.—

(1) In General.—On a weekly basis during the period described in subsection (a), the Secretary shall report to Congress on—
(A) the implementation of this section, including information on the amount, type, and geographic distribution of payments to qualified providers under this section; and

(B) any disparities in health and access to health care related to the COVID–19 outbreak or patient access to applicable health care items and services under this section, as identified through the collection and analysis of data collected under subsection (h).

(2) Public availability.—The Secretary shall make each report submitted under paragraph (1) publicly available on the internet website of the Department of Health and Human Services.

(j) Funding.—There are authorized to be appropriated such sums as are necessary to carry out this section.