

# THE MEDICARE FOR ALL ACT OF 2017

## **TITLE I—ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM**

Establishes a Universal Medicare Program for every resident of the United States, including the District of Columbia and the territories. Guarantees patients the freedom to choose their health care provider. Provides for the issuance of Universal Medicare cards that all residents may use to get the health care they need upon enrollment. Prohibits discrimination against anyone seeking benefits under this act.

Effective date of benefits: For children ages 0 to 18, benefits shall first be available on January 1 of the first calendar year that begins after enactment; for all others, benefits shall be made available on January 1 of the fourth calendar year that begins after enactment.

## **TITLE II—COMPREHENSIVE BENEFITS**

Requires coverage of the following benefits: hospital services, including emergency services and inpatient drugs; ambulatory patient services; primary and preventive services, including disease management; prescription drugs, medical devices, and biological products; mental health and substance abuse treatment services, including inpatient care; laboratory and diagnostic services; comprehensive reproductive, maternity, and newborn care; pediatrics; oral health, vision, and audiology; rehabilitative and habilitative services and devices; other items as deemed necessary.

States may provide additional benefits at their expense.

This section eliminates out-of-pocket spending for medical benefits, which includes deductibles, coinsurance, and copayments. The Secretary may impose limited copayments for prescription drugs in order to encourage the use of lower-cost generic drugs.

Long-term care coverage for seniors and people with disabilities will continue as it is currently covered under Medicaid, complete with a maintenance of effort provision; no one receiving benefits through Medicaid or any other federal or state health program will lose support.

## **TITLE III—PROVIDER PARTICIPATION**

Requires all providers to sign a participation agreement. Participation agreements may be terminated by the agency for cause, or by the provider for any reason.

Providers shall be considered qualified if they are properly licensed and certified under State and federal law to provide such services. Applies Medicare's current provider standards.

Allows providers to opt out of the system on an annual basis.

## **TITLE IV—ADMINISTRATION**

Establishes this program under the Department of Health and Human Services, run by the Secretary. Provides for general duties of the Secretary related to the administration, including developing policies, procedures, guidelines, and requirements related to eligibility, enrollment, benefits, provider participation, payment methods, and data collection.

Provides for a Beneficiary Ombudsman to assist individuals enrolled in the Act.

Applies all current Medicaid fraud provisions to this Act.

## **TITLE V—QUALITY ASSESSMENT**

Requires CMS' Center for Clinical Standards and Quality, in coordination with the Agency for Healthcare Research and Quality to review and evaluate all practice guidelines, profile practices and patterns of health care, conduct quality reviews, and report to the agency on outcomes research.

Requires the Center to evaluate and address health care disparities, and issue a report to Congress and the Secretary on such disparities.

## **TITLE VI—BUDGET AND PROVIDER PAYMENT**

Applies Medicare's current payment structures to Universal Medicare, including payment reform activities established by the ACA and MACRA.

Requires the agency to create an annual budget, which shall include the cost of covered health services; quality assessment activities; health professional education expenditures; administrative costs; innovation; operating and other expenditures; capital expenditures; and public health activities. For the first five years following the date of enactment, the budget may also provide transition assistance to health insurance administration workers who may be displaced because of the implementation of this Act. Provides for a reserve fund to anticipate natural disasters or other such public health emergencies.

Creates an Office of Primary Health to promote access to primary health care.

Requires the Secretary to negotiate the price of prescription drugs. Requires the Secretary to establish a prescription drug formulary for the Universal Medicare Program that is evidence-based and will encourage the use of generic drugs.

## **TITLE VII—UNIVERSAL HEALTH INSURANCE TRUST FUND**

Creates a trust fund for this Act. Includes all current federal health insurance program receipts, as well as all extra dollars attributed to changes in the Internal Revenue Code. Prohibits Hyde restrictions from following current appropriated funds into the Trust Fund.

## **TITLE VIII—ERISA CONFORMING AMENDMENTS**

Conforming amendments to the Employee Retirement Income Security Act of 1974. Prohibits employee benefits duplicative of the benefits under the Universal Medicare Program. Provides for coordination with employers in cases of workers' compensation.

## **TITLE IX—RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS**

Provides for a transition from Medicare, Medicaid, FEHB, SCHIP, and any other federal health insurance program into the Universal Medicare Program.

Nothing in this legislation will impact the eligibility of veterans for the medical benefits and services provided under the VA, or of Native Americans for the medical benefits and services provided by or through the Indian Health Service. Those benefits will be kept intact. Requires HHS to consult with tribal leaders and stakeholders before making any determination with respect to the Indian Health Service.

## **TITLE X—TRANSITION**

This section sets up a just transition to Universal Medicare. It will immediately improve and expand Medicare for seniors and people with disabilities by covering dental, vision and hearing aids which are not covered under current law. Medicare Part A, Part B, and Part D deductibles would also be eliminated in the first year.

A Medicare Transition plan would be established during the first year to provide affordable coverage for all Americans and to make sure that no one loses coverage.

During the second year of implementation, the Medicare eligibility age would be reduced to 45 and to 35 by the third year.

By the fourth year, every individual who is a resident of the United States will be entitled to benefits for comprehensive health care services and will get a Universal Medicare card that they can use to receive the health care they need.