119TH CONGRESS
1ST SESSION

S. _____

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

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM; UNIVERSAL ENTITLEMENT TO BENEFITS; ENROLLMENT

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

There is hereby established a national health insurance program (referred to in this Act as the ''Medicare for All Program'') to provide comprehensive protection against the costs of health care and health-related items and services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL ENTITLEMENT TO BENEFITS.

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

(b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary—

(1) may make eligible for benefits for health care items and services under this Act other individuals not described in subsection (a) and regulate

their eligibility to ensure that every person in the United States has access to health care; and

(2) shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care items and services provided under this Act.

SEC. 103. FREEDOM OF CHOICE.

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

SEC. 104. NON-DISCRIMINATION.

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

provider (as described in section 301(a)), or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

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

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

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

(c) CONTINUED APPLICATION OF LAWS.—Nothing in this title shall be construed to invalidate or otherwise limit any of the rights, remedies, procedures, or legal standards available to individuals aggrieved under other Federal laws, including section 1557 of the Patient Protection and

Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), title II of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131 et seq.), or the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.). Nothing in this title shall be construed to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

SEC. 105. ENROLLMENT.

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

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

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

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

(b) ISSUANCE OF MEDICARE FOR ALL CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the Secretary shall provide for the issuance of a Medicare for All card that shall be used for purposes of identification and processing of claims for benefits under the Medicare for All Program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

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

(b) IMMEDIATE COVERAGE OF CHILDREN.—

(1) IN GENERAL.—For any eligible individual under section 102 who has not yet attained the age of 19 as of the date that is 1 year after the date of enactment of this Act, benefits shall first be available under the Medicare for All Program for items and services furnished on January 1 of the first calendar year that begins after the date of enactment of this Act.

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

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—Beginning on the date on which benefits are first available under section 106(a), it shall be unlawful for—

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under the Medicare for All Program; or

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

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by the Medicare for All Program, including additional benefits that

an employer may provide to employees or their dependents, or to former employees or their dependents.

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

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the other provisions of this title and titles IV through IX, individuals enrolled for benefits under the Medicare for All Program are entitled to have payment made by the Secretary to a participating provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

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

(2) Ambulatory patient services.

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

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

(5) Mental health and substance use treatment services, including inpatient care and treatment for co-occurring mental illness and substance use disorders.

(6) Laboratory and diagnostic services.

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

(8) Comprehensive maternity and newborn care.

(9) Comprehensive gender affirming health care.

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

(11) Rehabilitative and habilitative services, including devices.

(12) Emergency services, including transportation.

(13) Pediatrics, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))).

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

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

(16) Home and community-based long-term care services and supports (to be provided in accordance with the requirements for home and community-based settings under sections 441.530 and 441.710 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), including—

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

(B) home and community-based services described in subsection (c)(4)(B) of section 1915 of the Social Security Act (42 U.S.C. 1396n) (including habilitation services defined in subsection (c)(5) of such section);

(C) self-directed home and community-based services described in subsection (i) of section 1915 of the Social Security Act;

(D) self-directed personal assistance services (as defined in subsection (j)(4)(A) of section 1915 of the Social Security Act); and

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

(17) Any item or service described in any of paragraphs (1) through (16) that is furnished using telehealth, to the extent practicable.

(b) REVISION.—The Secretary shall, at least on an annual basis, evaluate whether the benefits package should be improved to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to Congress regarding any such improvements.

(c) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

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

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

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

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

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

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and integrative medicine and the integration of such practices into the delivery of health care;

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

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

(d) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States, as determined by such State, and may provide benefits to individuals not eligible for benefits under the Medicare for All Program at the expense of the State.

SEC. 202. NO PATIENT COST-SHARING.

(a) IN GENERAL.—The Secretary shall ensure that no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual for any benefits provided under the Medicare for All Program, except as described in subsection (b).

(b) EXCEPTIONS.—The Secretary may set a cost-sharing schedule for prescription drugs covered under the Medicare for All Program—

(1) provided that—

(A) such schedule is evidence-based, patient-centered, and encourages the use of generic drugs;

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

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

(D) such cost-sharing is not imposed on individuals with a household income equal to or below 250 percent of the poverty line for a family of the size involved; and

(2) under which the Secretary may—

(A) exempt brand-name drugs from consideration in determining whether an individual has reached any out-of-pocket limit if a safe

and appropriate generic version of such drug is available to such individual; and

(B) waive cost-sharing in response to a coverage appeal under section 203(b)(2).

(c) NO BALANCE BILLING.—Notwithstanding contracts in accordance with section 303, no provider may impose a charge to an individual enrolled for benefits under the Medicare for All Program for items and services for which benefits are provided under such Program.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

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

(b) TREATMENT OF EXPERIMENTAL ITEMS AND SERVICES.—

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

(2) APPEALS PROCESS.—The Secretary shall establish a process by which individuals can appeal

coverage decisions. The process shall, as much as is feasible, follow the process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

(c) APPLICATION OF PRACTICE GUIDELINES.—

(1) IN GENERAL.—In the case of items and services for which the Department of Health and Human Services has recognized a national practice guideline, such items and services are considered to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline.

(2) CERTAIN EXCEPTIONS.—For purposes of this subsection, an item or service not provided in accordance with a national practice guideline shall be considered to have been provided in accordance with such guideline if the health care provider providing the item or service—

(A) exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline;

(B) acted in accordance with the laws and requirements in which such item or service is furnished;

(C) acted in the best interests of the individual receiving the item or service; and

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

SEC. 204. CONTINUED COVERAGE OF INSTITUTIONAL LONG-TERM CARE AND OTHER SERVICES UNDER MEDICAID.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting the following section after section 1948:

"SEC. 1949. STATE PLAN FOR PROVIDING INSTITUTIONAL LONG-TERM CARE SERVICES.

''(a) IN GENERAL.—For quarters beginning on or after the date on which benefits are first available under section 106(a) of the Medicare for All Act, notwithstanding any other provision of this title—

''(1) a State plan for medical assistance shall provide for making medical assistance available for institutional long-term care services in a manner consistent with this section; and

''(2) no payment to a State shall be made under this title with respect to expenditures incurred by the State in providing medical assistance on or after such date for services that are not—

''(A) institutional long-term care services; or

''(B) other services for which benefits are not available under the Medicare for All Act and which are furnished under a State plan for medical assistance which provided for medical assistance for such services on March 1, 2025.

''(b) INSTITUTIONAL LONG-TERM CARE SERVICES DEFINED.—In this section, the term 'institutional long-term care services' means the following:

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

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

''(3) Intermediate care facility services described in section 1905(a)(15).

''(4) Inpatient psychiatric hospital services for individuals under age 21 described in section 1905(a)(16).

''(5) Nursing facility services described in section 1905(a)(31).

''(c) STATE MAINTENANCE OF EFFORT REQUIREMENT.—

''(1) ELIGIBILITY STANDARDS.—

''(A) IN GENERAL.—Beginning on the date described in subsection (a), no payment may be made under section 1903 with respect to medical assistance provided under a State plan for medical assistance if the State adopts income, resource, or other standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan that are more restrictive than those applied as of January 1, 2025.

''(B) INDEXING OF AMOUNTS OF INCOME AND RESOURCE STANDARDS.—In determining whether a State has adopted income or resource standards that are more restrictive than the standards which applied as of January 1, 2025, the Secretary shall deem the amount of any such standard that was applied as of such date to be increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2022 to September of the fiscal year for which the Secretary is making such determination.

''(2) EXPENDITURES.—

"(A) IN GENERAL.—For each fiscal year or portion of a fiscal year that occurs during the period that begins on the first day of the first fiscal quarter that begins on or after the date on which benefits are first available under section 106(a) of the Medicare for All Act, as a condition of receiving payments under section 1903(a), a State shall make expenditures for medical assistance for institutional long-term care services in an amount that is not less than the expenditure floor determined for the State and fiscal year (or portion of a fiscal year) under subparagraph (B).

"(B) EXPENDITURE FLOOR.—

"(i) IN GENERAL.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall determine for each State an expenditure floor that shall be equal to—

"(I) the amount of the State's expenditures for fiscal year 2024 on medical assistance for institutional long-term care services; increased by

"(II) the growth factor determined under subclause (ii).

''(ii) GROWTH FACTOR.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall, not later than September 1 of the fiscal year preceding such fiscal year or portion of a fiscal year, determine a growth factor for each State that takes into account—

''(I) the percentage increase in health care costs in the State;

''(II) the total amount expended by the State for the previous fiscal year on medical assistance for institutional long-term care services;

''(III) the increase, if any, in the total population of the State from July of 2024 to July of the fiscal year preceding the fiscal year involved;

''(IV) the increase, if any, in the population of individuals aged 65 and older of the State from July of 2024 to July of the fiscal year preceding the fiscal year involved; and

''(V) the decrease, if any, in the population of the State that requires

medical assistance for institutional long-term care services that is attributable to the availability of coverage for the services described in section 201(a)(16) of the Medicare for All Act.

''(iii) PRORATION RULE.—Any amount determined under this subparagraph for a portion of a fiscal year shall be prorated based on the length of such portion of a fiscal year relative to a complete fiscal year.

''(d) NONAPPLICATION OF CERTAIN REQUIREMENTS.—Beginning on the date described in subsection (a), any provision of this title requiring a State plan for medical assistance to make available medical assistance for services that are not institutional long-term care services or items and services described in section 901(a)(3)(A)(ii) of the Medicare for All Act shall have no effect.''.

SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID MEDICAID BENEFITS.

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

(1) by amending subsection (a) to read as follows:

''(a) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual.''; and

(2) by amending subsection (b) to read as follows:

''(b) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made.''.

SEC. 206. ADDITIONAL STATE STANDARDS.

(a) IN GENERAL.—Nothing in this Act shall prohibit individual States from setting additional standards related to eligibility, benefits, and minimum provider standards, consistent with the purposes of this Act, provided that such standards do not restrict eligibility or reduce access to benefits for items and services.

(b) RESTRICTIONS ON PROVIDERS.—With respect to any individuals or entities certified to provide items and services covered under section 201(a)(7), a State may not prohibit an individual or entity from participating in the Medicare for All Program for reasons other than the in-

ability of the individual or entity to provide such items and services.

TITLE III—PROVIDER PARTICIPATION

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

(a) IN GENERAL.—An individual or entity furnishing any item or service covered under the Medicare for All Program is not a participating provider under such Program unless the individual or entity—

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

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

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

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

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

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

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

(i) quality review;

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

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

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

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

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

(F) In the case of an institutional provider paid pursuant to section 611, the provider agrees to submit information and any other required supporting documentation as may be reasonably required by the Secretary within 30 days after the date of providing items and services covered under the Medicare for All Pro-

gram and in accordance with the uniform reporting standards established under section 401(b)(1), including information on a quarterly basis that—

(i) relates to the provision of items and services covered under the Medicare for All Program; and

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

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

(i) to disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations under title VI or for meeting any other payment, documentation, or data collection requirements under this Act; and

(ii) not to use any such system or index to establish financial incentives or

disincentives for health care professionals, or that is proprietary, interferes with the medical or nursing process, or is designed to increase the amount or number of payments.

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

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

(2) PROVIDER DUTY OF ETHICS.—Each health care provider, including institutional providers, has a duty to advocate for and to act in the exclusive interest of each individual under the care of such provider according to the applicable legal standard of care, such that no financial interest or relationship impairs any health care provider's ability to furnish necessary and appropriate care to such individual.

To implement the duty established in this paragraph, the Secretary shall—

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

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

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

(3) TERMINATION OF PARTICIPATION AGREEMENT.—

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

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

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

(iii) by a provider.

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

(C) PROVIDER PROTECTIONS.—

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

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information re-

lating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this title;

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

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

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

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifica-

tions, burdens of proof, remedies, and statutes of limitation set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(c) WHISTLEBLOWER PROTECTIONS.—

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

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

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

(C) testified before or otherwise provided information relevant for Congress or for any Federal or State proceeding regarding any provision (or proposed provision) of this title;

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

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

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

(2) ENFORCEMENT ACTION.—Any employee covered by this section who alleges discrimination by an employer in violation of paragraph (1) may bring an action, subject to the statute of limitations described in section 3730(h)(3) of title 31, United States Code, and the rules and procedures, legal burdens of proof, and remedies applicable under section 31105 of title 49, United States Code.

(3) APPLICATION.—

(A) Nothing in this subsection shall be construed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or regulation, including the rights and remedies against retaliatory action under section 3730(h) of title 31, United States Code, or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

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

(4) DEFINITIONS.—In this subsection:

(A) EMPLOYER.—The term ''employer'' means any person engaged in profit or a nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organizations including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and subject to liability for violating the provisions of this Act.

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

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

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

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

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

(b) FEDERAL PROVIDERS.—Any provider qualified to provide health care items and services at a facility of the Department of Veterans Affairs, the Indian Health Service, or the uniformed services (as defined in section 1072(1) of title 10, United States Code) (with respect to the direct care component of the TRICARE program) is a qualified provider under this section with respect to any individual who qualifies for such items and services under applicable Federal law.

(c) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of items and services provided under the Medicare for All Program and to monitor efforts by States to ensure the quality of

such items and services. A State may also establish additional minimum standards which providers shall meet with respect to items and services provided in such State.

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

(A) adequacy and quality of facilities;

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

(C) comprehensiveness of items and services;

(D) continuity of items and services;

(E) patient waiting times, access to items and services, and references; and

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

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

SEC. 303. USE OF PRIVATE CONTRACTS.

(a) IN GENERAL.—This section shall apply beginning on the date on which benefits are first available under section 106(a). Subject to the provisions of this section, nothing in this Act shall prohibit an institutional or individual provider from entering into a private contract with an individual enrolled for benefits under the Medicare for All Program for any item or service—

(1) for which no claim for payment is to be submitted under this Act; and

(2) for which the provider receives—

(A) no reimbursement under this Act directly or on a capitated basis; and

(B) receives no amount from an organization which receives reimbursement for such item or service under this Act directly or on a capitated basis.

(b) CONTRACT REQUIREMENTS.—

(1) IN GENERAL.—Any contract to provide an item or service under subsection (a) shall—

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

(B) be entered into at a time when the individual is facing an emergency health care situation; and

(C) contain the items described in paragraph (2).

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide an item or service to which subsection (a) applies shall clearly indicate to the individual that by signing such contract the individual—

(A) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such item or service even if such

item or service is otherwise covered by the Medicare for All Program;

(B) agrees to be responsible, whether through insurance offered under section 107(b) or otherwise, for payment of such item or service and understands that no reimbursement will be provided under this Act for such item or service;

(C) acknowledges that no limits under this Act apply to amounts that may be charged for such item or service;

(D) if the provider is a nonparticipating provider, acknowledges that the beneficiary has the right to have such item or service provided by other providers for whom payment would be made under the Medicare for All Program; and

(E) acknowledges that the provider is providing an item or service outside the scope of the Medicare for All Program.

(c) PROVIDER REQUIREMENTS.—

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

(2) AFFIDAVIT.—An affidavit as described in this subparagraph shall—

(A) identify the provider, and be signed by such provider;

(B) provide that the provider will not submit any claim under this title for any item or service provided to any beneficiary (and will not receive any reimbursement or amount described in subsection (a)(2) for any such item or service) during the 1-year period beginning on the date the affidavit is signed; and

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

(3) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (2) knowingly and willfully submits a claim under this title for any item or service provided during the 1-year period described in paragraph (2)(B) (or receives any reimbursement or amount described in subsection (a)(2) for any such item or service) with respect to such affidavit—

(A) this subsection shall not apply with respect to any item or service provided by the provider pursuant to any contract on and after

the date of such submission and before the end of such period; and

(B) no payment shall be made under this title for any item or service furnished by the provider during the period described in subparagraph (A) (and no reimbursement or payment of any amount described in subsection (a)(2) shall be made for any such item or service).

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

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

(A) eligibility for benefits under the Medicare for All Program;

(B) enrollment under such Program;

(C) benefits provided under such Program;

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

(E) levels of funding;

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

(G) a process for appealing or petitioning for a determination of coverage for items and services under the Medicare for All Program;

(H) planning for capital expenditures and item and service delivery;

(I) planning for health professional education funding;

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

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

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

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

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements, provider reporting requirements, and national standards to ensure an adequate national data-

base containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and services covered under the Medicare for All Program, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures used under this Act, and to the maximum extent feasible without excessively burdening providers, the measures described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REPORTS.—The Secretary shall—

(i) regularly analyze information reported to the Secretary; and

(ii) define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

(2) ANNUAL REPORT.—Beginning January 1 of the second year beginning after the date on which benefits are first available under section 106(a), the Secretary shall annually report to Congress on the following:

(A) The status of implementation of this Act.

(B) Enrollment under the Medicare for All Program.

(C) Benefits under the Medicare for All Program.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under the Medicare for All Program.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the Medicare for All Program.

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

(I) Differences in the health status of the populations of the different States, by demographic characteristics, including race, eth-

nicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socio-economic status.

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

(K) Plans for improving items and services to medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))).

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

(M) Opportunities for improvements under this Act.

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

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

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

or for the improvement, of the operation of this Act; and

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

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an audit of the Department of Health and Human Services every fifth fiscal year following the date on which benefits are first available under section 106(a) to determine the effectiveness of the Medicare for All Program in carrying out the duties under subsection (a).

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

SEC. 402. CONSULTATION.

The Secretary shall consult with Federal agencies, Indian Tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic health centers, consumer groups, patient advocate groups, disability rights organizations, and labor business organizations in the for-

mulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines, consistent with section 203(c), developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 403. REGIONAL ADMINISTRATION.

(a) REGIONAL MEDICARE FOR ALL OFFICES.—The Secretary shall establish and maintain regional offices for the purpose of carrying out the duties specified in subsection (c) and promoting adequate access to, and efficient use of, tertiary care facilities, equipment, items, and services by individuals enrolled under the Medicare for All Program.

(b) COORDINATION.—Wherever possible, the Secretary shall incorporate the regional offices and the administrative processes of the Centers for Medicare & Medicaid Services for the purposes of carrying out subsection (a).

(c) APPOINTMENT OF REGIONAL DIRECTORS.—In each regional office established under subsection (a) there shall be—

(1) one regional director appointed by the Secretary;

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

(3) one deputy director appointed by the regional director to oversee home- and community-based services and supports.

(d) DUTIES.—Each regional director shall—

(1) submit an annual regional health care needs assessment report to the Secretary, after a thorough examination of health needs and consultation with public health officials, clinicians, patients, and patient advocates;

(2) recommend any changes in provider reimbursement or payment for delivery of items and services covered under the Medicare for All Program determined appropriate by the regional director, subject to the requirements of title VI; and

(3) establish a quality assurance mechanism in each such region in order to minimize both under-utilization and over-utilization of health care items and services covered under the Medicare for All Program and to ensure that all participating providers

described in section 301(a) meet the quality and other standards established pursuant to this Act.

SEC. 404. BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education and in providing assistance to individuals entitled to benefits under the Medicare for All Program.

(b) DUTIES.—

(1) IN GENERAL.—The Beneficiary Ombudsman shall—

(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under the Medicare for All Program with respect to any aspect of such Program;

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

(ii) assistance to such individuals in presenting information relating to cost-sharing; and

(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate.

(2) AUTHORITIES.—The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of items or services, but may identify issues and problems in payment or coverage policies.

SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.

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

Subtitle B—Control Over Fraud and Abuse

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

The following sections of the Social Security Act shall apply to the Medicare for All Program in the same manner as they apply to State medical assistance plans under title XIX of such Act (42 U.S.C. 1396 et seq.):

(1) Section 1128 (42 U.S.C. 1320a–7) (relating to exclusion of individuals and entities).

(2) Section 1128A (42 U.S.C. 1320a–7a) (civil monetary penalties).

(3) Section 1128B (42 U.S.C. 1320a–7b) (criminal penalties).

(4) Section 1124 (42 U.S.C. 1320a–3) (relating to disclosure of ownership and related information).

(5) Section 1126 (42 U.S.C. 1320a–5) (relating to disclosure of certain owners).

(6) Section 1877 (42 U.S.C. 1395nn) (relating to physician referrals).

TITLE V—QUALITY OF CARE

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be implemented and evaluated

by the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this title as the ''Center'') or such other agencies determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

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

(1) Review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299b et seq.). In so reviewing and evaluating, the Center shall determine whether the guideline should be recognized as a national practice guideline in accordance with and subject to section 203(c).

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

disabilities is prohibited for use in any value or cost-effectiveness assessments. The Center shall consider the evidentiary basis for the standard, and the validity, reliability, and feasibility of measuring the standard.

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

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

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

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center, in coordination with the Office of Health Equity established under section 1712 of the Public Health Service Act (as added by section 616) and other agencies in the Department of Health and Human Services determined relevant by the Secretary, shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accurate, and timely collection of data on disparities in health care items and services and performance on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status. In conducting such evaluation, the Center shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers under the Medicare for All Program.

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

(b) REPORTS TO CONGRESS.—

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

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status under the Medicare for All Program; and

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

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under paragraph (1), and every 4 years thereafter,

the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 2 years after the date on which benefits are first available under section 106(a), the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

TITLE VI—NATIONAL HEALTH BUDGET; PROVIDER PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—Not later than September 1 of each year, beginning with the year prior to the date on which benefits are first available under sec-

tion 106(a), the Secretary shall establish a national health budget, which specifies a budget for the total expenditures to be made for items and services covered under the Medicare for All Program.

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

(A) An operating budget.

(B) A capital expenditures budget.

(C) A special projects budget.

(D) Quality assessment activities under title V.

(E) Health professional education expenditures.

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

(G) A reserve fund.

(H) Prevention and public health activities.

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

(A) that the operating budget allows for every participating provider in the Medicare for

All Program to meet the needs of their respective patient populations;

(B) that the special projects budget is sufficient to meet the health care needs within areas described in paragraph (7) through the construction, renovation, and staffing of health care facilities in a reasonable timeframe;

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

(D) that the health professional education expenditure component described in paragraph (2)(E) is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for items and services covered under the Medicare for All Program.

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

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

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

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

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

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

(B) major equipment purchases.

(7) SPECIAL PROJECTS BUDGET.—The special projects budget described in paragraph (2)(C) shall be used for the purposes of allocating funds for the construction of new facilities, major equipment purchases, and staffing in rural areas or areas described in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))), and to address health dis-

parities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

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

(9) CONSTRUCTION COMPLIANCE.—Expenditures from each component of the national health budget, including construction, shall expand accessibility for persons with disabilities to achieve full compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.). Any project funded through the national budget shall at least meet the new construction standards under such Act.

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for major equipment.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional edu-

cation expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities, including the impact of workforce recruitment, retention, and diversity on patient outcomes.

SEC. 602. TEMPORARY WORKER ASSISTANCE.

(a) IN GENERAL.—For up to 5 years following the date on which benefits are first available under section 106(a), at least 1 percent of the national health budget shall be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system, or related functions within health care institutions or organizations, who may experience economic dislocation as a result of the implementation of this Act.

(b) CLARIFICATION.—Assistance described in subsection (a) shall include wage replacement, retirement benefits, job training and placement, preferential hiring, and education benefits.

Subtitle B—Payments to Providers

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

(a) IN GENERAL.—Not later than the beginning of each fiscal quarter during which an institutional provider of care (including hospitals, skilled nursing facilities, and

independent dialysis facilities) is to furnish items and services under the Medicare for All Program, the Secretary shall pay to such institutional provider a lump sum in accordance with the succeeding provisions of this subsection and consistent with the following:

(1) PAYMENT IN FULL.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under the Medicare for All Program, whether inpatient or outpatient, by such provider for such quarter, including outpatient or any other care provided by the institutional provider or provided by any health care provider who provided items and services pursuant to an agreement paid through the global budget as described in paragraph (3).

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

tient volume, and an assessment of any adjustments made to ensure that accuracy and need for adjustment was appropriate.

(3) AGREEMENTS FOR SALARIED PAYMENTS FOR CERTAIN PROVIDERS.—

(A) IN GENERAL.—Certain group practices and other health care providers, as determined by the Secretary, with agreements to provide items and services at a specified institutional provider paid a global budget under this subsection may elect to be paid through such institutional provider's global budget in lieu of payment under section 612.

(B) SALARIES.—Any individual health care professional of such group practice or other provider receiving payment through an institutional provider's global budget under this paragraph shall be paid on a salaried basis that is equivalent to salaries or other compensation rates negotiated for individual health care professionals of such institutional provider.

(C) REPORTING AND DISCLOSURE REQUIREMENTS.—Any group practice or other health care provider that receives payment through an institutional provider's global budg-

et under this paragraph shall be subject to the same reporting and disclosure requirements of the institutional provider.

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

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

(i) natural disasters;

(ii) public health emergencies including outbreaks of epidemics or infectious diseases;

(iii) unexpected facility or equipment repairs or purchases;

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

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

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

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

(b) PAYMENT AMOUNT.—

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

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

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

(B) the actual expenditures of such provider in such provider's most recent cost report under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for each item and service compared to—

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

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

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

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

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

(F) education and prevention programs;

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

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

(ii) efforts to decrease health care disparities in rural areas or areas described in section 330(b)(3) of the Public Health

Service Act (42 U.S.C. 254b(b)(3)), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)));

(iii) a response to emergent epidemic conditions;

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

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

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

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

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

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

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

(C) exceed the provider's capacity to provide care under the Medicare for All Program; or

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

(4) LIMITATION ON COMPENSATION.—Compensation costs for any employee or any contractor or any subcontractor employee of an institutional provider receiving global budgets under this section shall not exceed the compensation cap established in section 4304(a)(16) of title 41, United States Code, as added by section 702 of the Bipartisan Budget Act of 2013, and implementing regulations.

(5) REGIONAL NEGOTIATIONS PERMITTED.—Subject to section 614, a regional director may negotiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market shifts related to patient volume.

(c) BASELINE RATES AND ADJUSTMENTS.—

(1) IN GENERAL.—The Secretary shall use existing prospective payment systems under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to serve as the comparative payment rate system in global budget negotiations described in subsection (b). The Secretary shall update such comparative payment rate systems annually.

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

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

(4) INITIAL YEAR.—In the first year that global budget payments under this Act are available to institutional providers and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for each institutional provider, the Secretary shall take into account the appropriate prospective payment system from the most recent year under title XVIII of the Social Security

Act to determine what operating base payment the institutional provider would have been paid for items and services covered under the Medicare for All Program furnished the preceding year with applicable adjustments, including adjustments due to any public health emergencies in the preceding year, and excluding value-based payment adjustments, based on such prospective payment system.

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

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

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

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

(C) Costs of all pharmaceutical products administered by health care clinicians at the in-

stitutional provider's facilities or through items or services provided in accordance with State licensing laws or regulations under which the institutional provider operates.

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

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

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

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

(2) Administrative costs for the institutional provider.

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

(a) MEDICARE FOR ALL FEE SCHEDULE.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, and in consultation with providers and regional office directors, the Secretary shall establish and annually update a national fee schedule that establishes amounts for items and services payable under the Medicare for All Program, furnished by—

(A) individual providers;

(B) providers in group practices who are not receiving payments on a salaried basis described in section 611(a)(3);

(C) providers of home- and community-based services; and

(D) any other provider not described in section 611.

(2) AMOUNTS.—In establishing the fee schedule under paragraph (1), the Secretary shall take into account—

(A) the amounts payable for such items and services under title XVIII of the Social Se-

curity Act and other Federal health programs; and

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

(b) LEVERAGING EXISTING MEDICARE PAYMENT PROCESSES.—

(1) APPLICATION OF PAYMENT PROCESSES UNDER TITLE XVIII.—Except as otherwise provided in this section, the Secretary shall establish, and shall annually update by regulation, the fee schedule under subsection (a) in a manner that is documented, is transparent, allows for public comment, and, to the greatest extent practicable, is consistent with processes for determining, revising, and making payments for items and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including the application of the provisions of, and amendments made by, section 613.

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

(c) APPLICATION OF CURRENT AND PLANNED PAYMENT REFORMS.—To the extent the Secretary determines

such application is necessary to ensure a smooth and fair transition, the Secretary may apply payment reform activities planned or implemented with respect to such title XVIII as of the date of the enactment of this Act, including demonstrations, waivers, or any other provider payment agreements, to benefits under the Medicare for All Program, provided that the Secretary sets forth a process for reviewing such applications and making such determinations that is reasonable, transparent, and documented, and allows for public comment.

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

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

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

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

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

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

(b) PLANNED AND DOCUMENTED USE OF FUNDS.—Section 1848(c)(2)(M) of the Social Security Act (42 U.S.C. 1305w–4(c)(2)(M)) is amended by adding at the end the following new clause:

''(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning

on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.''.

(c) INTERNAL TRACKING OF REVIEWS.—

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

(2) MINIMUM REQUIREMENTS.—The proposal shall include, at a minimum, plans and a timeline for achieving the ability to systematically and internally track the following:

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

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

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

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

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

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

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

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

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

(A) in subparagraph (B)(i), by inserting ''in consultation with the Medicare Payment Advisory Commission,'' after ''The Secretary,''; and

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

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

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

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

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

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

''(i) IN GENERAL.—The Comptroller General of the United States (in this subparagraph referred to as the 'Comptroller General') shall periodically audit the review

by the Secretary of relative values established under this paragraph for physicians' services.

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

SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.

(a) NEGOTIATED PRICES.—The prices to be paid for pharmaceutical products, medical supplies, and medically necessary assistive equipment covered under the Medicare for All Program shall be negotiated annually by the Secretary.

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Secretary shall establish a prescription drug formulary system, pursuant to the requirements of section 202, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary under this subsection shall promote the

use of generic medications to the greatest extent possible.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary under this subsection shall be updated frequently and clinicians and patients may petition the Secretary to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

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

SEC. 615. PAYMENT PROHIBITIONS; CAPITAL EXPENDITURES; SPECIAL PROJECTS.

(a) PROHIBITIONS.—Payments to participating providers described in section 301(a) may not take into account, include any process for the provision of funding for, or be used by a provider for—

(1) marketing of the provider;

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

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

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

(b) PAYMENTS FOR CAPITAL EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall pay, from amounts made available for capital expenditures pursuant to section 601(a)(2)(B), such sums determined appropriate by the Secretary to providers who have submitted an application to the regional director of the region or regions in which the provider operates or seeks to operate in a time and manner specified by the Secretary for purposes of funding capital expenditures of such providers.

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

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

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

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

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

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

(d) PAYMENTS FOR SPECIAL PROJECTS.—

(1) IN GENERAL.—The Secretary shall allocate to each regional director, from amounts made available for special projects pursuant to section 601(a)(2)(C), such sums determined appropriate by the Secretary for purposes of funding projects described in such section, including the construction, renovation, or staffing of health care facilities in rural, underserved, or health professional or medical shortage areas within such region and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, or socioeconomic health disparities. Each regional director shall, prior to distributing such funds in accordance with paragraph (2), present a budget describing how such funds will be distributed to the Secretary.

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

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

SEC. 616. OFFICE OF HEALTH EQUITY.

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

"SEC. 1712. OFFICE OF HEALTH EQUITY.

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

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

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

''(A) the disproportionate burden of disease and death among people of color,

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

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

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

''(i) lack of trust and awareness;

''(ii) lack of transportation;

''(iii) lack of accessibility;

''(iv) geography;

''(v) hospital and service closures;

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

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

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

''(E) disparities in utilization of care.

''(2) ANALYSIS OF CROSS-SECTIONAL INFORMATION.—The Director of the Office of Health Equity shall ensure that the data collection and reporting process under paragraph (1) allows for the analysis of cross-sectional information on people's identities.

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

''(1) providing recommendations on—

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

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

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

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

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

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

''(1) statistics collected by the Office;

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

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

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

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

tion), incarceration, homelessness, geography, and socioeconomic status; and

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

''(g) PRIVACY.—Notwithstanding any other Federal or State law, no Federal or State official or employee or other entity shall disclose, or use, for any law enforcement or immigration purpose, any personally identifiable information (including with respect to an individual's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status) that is collected or maintained pursuant to this section.''.

SEC. 617. OFFICE OF PRIMARY HEALTH CARE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.), as amended by section 616, is further amended by adding at the end the following:

''SEC. 1713. OFFICE OF PRIMARY HEALTH CARE.

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

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

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

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

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

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

''(2) develop and maintain a system to monitor the number and specialties of individuals pursuing careers in, or practicing, primary health care

through their health professional education, any postgraduate training, and professional practice;

''(3) develop, coordinate, and promote policies that expand the number of primary health care practitioners including primary medical, dental, and behavioral health care providers, registered nurses, and other advanced practice clinicians;

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

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

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

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

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

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

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

TITLE VII—MEDICARE FOR ALL TRUST FUND

SEC. 701. MEDICARE FOR ALL TRUST FUND.

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

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits are first available under section 106(a), out of any moneys in the Treasury not otherwise appropriated,

amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by section 801 and section 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—

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

(i) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (other than amounts attributable to any premiums under such title).

(ii) The Medicaid program under State plans approved under title XIX of such Act (42 U.S.C. 1396 et seq.).

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

(iv) The maternal and child health program (under title V of the Social Security Act (42 U.S.C. 701 et seq.)), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health care items and services the payment of which may be made under this Act.

(B) SUBSEQUENT YEARS.—Notwithstanding any other provision of law, there is appropriated to the Trust Fund for each fiscal year following the fiscal year in which the appropriation is made under subparagraph (A), an amount equal to the amount appropriated to the Trust Fund for the previous year, adjusted for reductions in costs resulting from the implementation of this Act, changes in the consumer price index for all urban consumers for the fiscal year involved, and other factors determined appropriate by the Secretary.

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

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

of Trustees of the Trust Fund'' or the ''Board of Trustees'' shall mean the ''Secretary''.

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

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

SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER THE MEDICARE FOR ALL PROGRAM; COORDINATION IN CASE OF WORKERS' COMPENSATION.

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

"SEC. 524. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF MEDICARE FOR ALL PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

''(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Program established under section 101 of the Medicare for All Act (referred to in this section as the 'Medicare for All Program').

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

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

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

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

under such laws with respect to such an employee; and

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

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 524(b) (relating to reimbursement of the Medicare for All Program by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 523 the following new item:

''Sec. 524. Prohibition of employee benefits duplicative of Medicare for All Program benefits; coordination in case of workers' compensation.''.

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

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

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

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

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

(3) Section 502(e) of such Act (29 U.S.C. 1132(e)) is amended by striking ''paragraphs (1)(B) and (7)'' and inserting ''paragraph (1)(B)''.

(4) Section 502(l)(3)(B) of such Act (29 U.S.C. 1132(l)(3)(B)) is amended by striking ''subsection (a)(9)'' and inserting ''subsection (a)(8)''.

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

(A) in paragraph (7), by striking ''section 206(d)(3)(B)(i)),''; and

(B) by striking paragraph (8).

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

SEC. 803. EFFECTIVE DATE OF TITLE.

The provisions of and amendments made by this title shall take effect on the date on which benefits are first available under section 106(a).

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

(A) no benefits shall be available under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for any item or service furnished beginning on or after the date on

which benefits are first available under section 106(a);

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act (42 U.S.C. 1396 et seq.) for any item or service furnished on or after such date;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act (42 U.S.C. 1397aa et seq.) for any item or service furnished on or after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act (42 U.S.C. 1396b(a); 42 U.S.C. 1397ee) with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the date on which benefits are first available under section 106(a), and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan

under title XIX of such Act, or under a State child health plan under title XXI of such Act, the Secretary shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(3) CONTINUED COVERAGE OF LONG-TERM CARE AND OTHER CERTAIN SERVICES UNDER MEDICAID.—

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

(i) institutional long-term care services (as defined in section 1948(b) of such Act); or

(ii) any other service for which benefits are not available under the Medicare for All Program and which is furnished under a State plan under title XIX of the Social Security Act which provided for medical assistance for such service on January 1, 2023.

(B) COORDINATION BETWEEN SECRETARY AND STATES.—The Secretary shall coordinate with the directors of State agencies responsible

for administering State plans under title XIX of the Social Security Act to—

(i) identify items and services described in subparagraph (A)(ii) with respect to each State plan; and

(ii) ensure that such items and services continue to be made available under such plan.

(C) STATE MAINTENANCE OF EFFORT REQUIREMENT.—With respect to any service described in subparagraph (A)(ii) that is made available under a State plan under title XIX of the Social Security Act, the maintenance of effort requirements described in section 1948(c) of such Act (related to eligibility standards and required expenditures) shall apply to such service in the same manner that such requirements apply to institutional long-term care services (as defined in section 1948(b) of such Act).

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

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

(1) IN GENERAL.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, the eligibility of individuals for TRICARE medical benefits and services provided under sections 1079 and 1086 of title 10, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

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

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

Effective on the date on which benefits are first available under section 106(a), the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

TITLE X—TRANSITION TO MEDICARE FOR ALL

Subtitle A—Improvements to Medicare

SEC. 1001. PROTECTING MEDICARE FEE-FOR-SERVICE BENEFICIARIES FROM HIGH OUT-OF-POCKET COSTS.

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

''PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

''SEC. 1899C. (a) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (effective the year beginning January 1 of the year following the date of enactment of the Medicare for All Act) equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing that occurred during that year.

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

"(1) IN GENERAL.—Subject to paragraphs (2) and (3), in this section, the term 'out-of-pocket cost-sharing' means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

"(A) coinsurance and copayments applicable under part A or B; or

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

"(2) CERTAIN COSTS NOT INCLUDED.—

"(A) NON-COVERED ITEMS AND SERVICES.—Expenses incurred for items and services which are not included (or treated as being included) under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

"(B) ITEMS AND SERVICES NOT FURNISHED ON AN ASSIGNMENT-RELATED BASIS.—If an item or service is furnished to an individual under this title and is not furnished on an assignment-related basis, any additional expenses the individual incurs above the amount the individual would have incurred if the item

or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

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

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

(1) PART A.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended by adding at the end the following new paragraph:

''(4) For each year (beginning January 1 of the year following the date of enactment of the Medicare for All Act), the inpatient hospital deductible for the year shall be $0.''.

(2) PART B.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended, in the first sentence—

(A) by striking ''and for a subsequent year'' and inserting ''for each of 2006 through

the year that includes the date of enactment of the Medicare for All Act''; and

(B) by inserting '', and $0 for each year subsequent year'' after ''$1)''.

SEC. 1002. REDUCING MEDICARE PART D ANNUAL OUT-OF-POCKET THRESHOLD.

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

(1) in clause (i), by striking ''For purposes'' and inserting ''Subject to clause (iii), for purposes''; and

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

''(iii) REDUCTION IN THRESHOLD DURING TRANSITION PERIOD.—

''(I) IN GENERAL.—Subject to subclause (II), for plan years beginning on or after January 1 following the date of enactment of the Medicare for All Act and before January 1 of the year that is 4 years following such date of enactment, notwithstanding clauses (i) and (ii), the 'annual out-of-pocket threshold' specified in this subparagraph is equal to $300.

''(II) AUTHORITY TO EXEMPT BRAND-NAME DRUGS IF GENERIC AVAILABLE.—In applying subclause (I), the Secretary may exempt costs incurred for a covered part D drug that is an applicable drug under section 1860D–14A(g)(2) if the Secretary determines that a generic version of that drug is available.''.

SEC. 1003. EXPANDING MEDICARE TO COVER DENTAL AND VISION SERVICES AND HEARING AIDS AND EXAMINATIONS UNDER PART B.

(a) DENTAL SERVICES.—

(1) REMOVAL OF EXCLUSION FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by striking paragraph (12).

(2) COVERAGE.—

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

(i) in subparagraph (JJ), by inserting ''and'' at the end; and

(ii) by adding at the end the following new subparagraph:

''(KK) dental services;''.

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

(i) by striking ''and'' before ''(HH)''; and

(ii) by inserting before the semicolon at the end the following: ''and (II) with respect to dental services described in section 1861(s)(2)(KK), 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).''.

(C) 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.

(b) VISION SERVICES.—

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

(A) in subparagraph (JJ), by striking ''and'' at the end;

(B) in subparagraph (KK), by inserting ''and'' at the end; and

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

''(LL) 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 ''(II)''; and

(B) by inserting before the semicolon at the end the following: '', and (JJ) with respect to vision services described in section 1861(s)(2)(LL), 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 furnished on or after January 1 following the date of the enactment of this Act.

SEC. 1004. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

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

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

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

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

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

month following the month in which the individual meets the requirements of such paragraph, and''; and

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

(b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before January 1 of the year that is 4 years after such date of enactment.

SEC. 1005. GUARANTEED ISSUE OF MEDIGAP POLICIES.

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

''(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELIGIBLE MEDICARE BENEFICIARIES.—Notwithstanding paragraphs (2)(A) and (2)(D) of subsection (s) or any other provision of this section, on or after the date of enactment of this subsection, the issuer of a Medicare supplemental policy may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, or dis-

criminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of any individual entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B.''.

Subtitle B—Temporary Medicare Buy-In Option and Temporary Public Option

SEC. 1011. LOWERING THE MEDICARE AGE.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), as amended by section 1001, is amended by adding at the end the following new section:

''TEMPORARY MEDICARE BUY-IN OPTION FOR CERTAIN INDIVIDUALS

''SEC. 1899D. (a) NO EFFECT ON OTHER BENEFITS FOR INDIVIDUALS OTHERWISE ELIGIBLE OR ON TRUST FUNDS.—The Secretary shall implement the provisions of this section in such a manner to ensure that such provisions—

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

''(2) have no negative impact on the Federal Hospital Insurance Trust Fund or the Federal Sup-

plementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund).

''(b) OPTION.—

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

''(2) PART A, B, AND D BENEFITS.—An individual enrolled under this section is entitled to the same benefits (and shall receive the same protections) under this title as an individual who is entitled to benefits under part A and enrolled under parts B and D, including the ability to enroll in a private plan that provides qualified prescription drug coverage.

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

''(A) The individual is a resident of the United States.

''(B) The individual is—

''(i) a citizen or national of the United States; or

''(ii) an alien lawfully admitted for permanent residence.

"(C) The individual is not otherwise entitled to benefits under part A or eligible to enroll under part A or part B.

"(D) The individual has attained the applicable years of age but has not attained 65 years of age.

"(4) APPLICABLE YEARS OF AGE DEFINED.—For purposes of this section, the term 'applicable years of age' means—

"(A) effective January 1 of the first year following the date of enactment of the Medicare for All Act, the age of 55;

"(B) effective January 1 of the second year following such date of enactment, the age of 45; and

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

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

"(d) PREMIUM.—

"(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with the first September following the date of enactment of the Medicare for All Act), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1/12 of the annual premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

"(2) ANNUAL PREMIUM.—

"(A) COMBINED PER CAPITA AVERAGE FOR ALL MEDICARE BENEFITS.—The Secretary shall estimate the average, annual per capita amount for benefits and administrative expenses that will be payable under parts A, B, and D in the year for all individuals enrolled under this section.

"(B) ANNUAL PREMIUM.—The annual premium under this subsection for months in a year is equal to the average, annual per capita amount estimated under subparagraph (A) for the year.

''(3) INCREASED PREMIUM FOR COMPLEMENTARY PLANS.—Nothing in this section shall preclude an individual from choosing a prescription drug plan or other complementary plans which requires the individual to pay an additional amount (because of supplemental benefits or because it is a more expensive plan). In such case the individual would be responsible for the increased monthly premium.

''(e) PAYMENT OF PREMIUMS.—

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

''(2) DEPOSIT.—Amounts collected by the Secretary under this section shall be deposited in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund) in such proportion as the Secretary determines appropriate.

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

''(g) TREATMENT IN RELATION TO THE AFFORDABLE CARE ACT.—

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

''(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—Coverage provided under this section—

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

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

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

''(3) ELIGIBILITY FOR COST-SHARING SUBSIDIES.—For purposes of applying section 1402 of

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

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

''(B) the Secretary shall be treated as the issuer of such plan.

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

SEC. 1012. ESTABLISHMENT OF THE MEDICARE TRANSITION PLAN.

(a) IN GENERAL.—To carry out the purpose of this section, for plan years beginning with the first plan year that begins after the date of enactment of this Act and ending with the date on which benefits are first available under section 106(a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the ''Administrator''), shall establish, and provide for the offering through the Exchanges, of a public health plan (in this Act referred to

as the ''Medicare Transition plan'') that provides affordable, high-quality health benefits coverage throughout the United States.

(b) ADMINISTRATING THE MEDICARE TRANSITION.—

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

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

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

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

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

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

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

(d) PROVIDERS AND REIMBURSEMENT RATES.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition plan, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.). For items and services covered under the Medicare Transition plan but not covered under such parts A and B, the Administrator shall reimburse providers at rates set by the Administrator in a manner consistent with the man-

ner in which rates for other items and services were set under the original Medicare fee-for-service program.

(2) PRESCRIPTION DRUGS.—Any payment rate under this subsection for a prescription drug shall be at a rate negotiated by the Administrator with the manufacturer of the drug. If the Administrator is unable to reach a negotiated agreement on such a reimbursement rate, the Administrator shall establish the rate at an amount equal to the lesser of—

(A) the price paid by the Secretary of Veterans Affairs to procure the drug under the laws administered by the Secretary of Veterans Affairs;

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

(C) the best price determined under section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42

U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this Act shall be a participating provider in the Medicare Transition plan.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition plan. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) PREMIUMS.—

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

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

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Af-

fordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

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

(f) TERMINATION.—The provisions of this section shall cease to have force or effect on the date on which benefits are first available under section 106(a).

(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), (D), and (E) as subparagraphs (D), (E), and (F), 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 1012(a) of the Medicare for All Act for all months in the taxable year, subparagraph (A) shall be applied without regard to 'but does not exceed 400 percent'. The preceding sentence shall not apply to any taxable year to which subparagraph (E) applies.

''(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for All Act) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1012(a) of the Medicare for All Act

for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.''.

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

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

(I) by redesignating clauses (ii) and (iii) as clauses (iii) and (iv), respectively;

(II) by striking ''clause (ii)'' in clause (i) and inserting ''clauses (ii) and (iii)''; and

(III) by inserting after clause (i) the following new clause:

''(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—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 1012(a) of the Medicare for All Act

for all months in the taxable year the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent	2	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.

The preceding sentence shall not apply to any taxable year to which clause (iv) applies.".

(ii) CONFORMING AMENDMENTS.—

(I) Subclause (I) of clause (iii) of section 36B(b)(3)(A) of such Code, as redesignated by subparagraph (A)(i), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(II) Section 36B(b)(3)(A)(iv)(I) of such Code, as redesignated by subparagraph (A)(i), is amended by strik-

ing ''clause (ii)'' and inserting ''clause (iii)''.

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

(A) by inserting '', or in the Medicare Transition plan established under section 1012(a) of the Medicare for All Act,'' after ''coverage'' in paragraph (1);

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

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

''(1) IN GENERAL.—In this section'';

(D) by striking the flush language; and

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

''(2) SPECIAL RULES.—

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

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

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

''(C) ADJUSTED COST-SHARING FOR MEDICARE TRANSITION PLAN ENROLLEES.—In the case of any individual who enrolls in such Medicare Transition plan, in lieu of the percentages under subsection (c)(1)(B)(i) and (c)(2), the Secretary shall prescribe a method of determining 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 under section 1012 of the Medicare for All Act,'' 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 under section 1012 of the Medicare for All Act,'' before ''or a multi-State qualified health plan''.

Subtitle C—Patient Protections During Medicare for All Transition Period

SEC. 1021. MINIMIZING DISRUPTIONS TO PATIENT CARE.

The Secretary shall ensure that all individuals enrolled in, or who seek to enroll in, a group health plan, health insurance coverage offered by a health insurance issuer, or the plan established under section 1012 during the transition period of this Act are protected from disruptions in their care during the transition period.

SEC. 1022. PUBLIC CONSULTATION.

The Secretary shall consult with communities and advocacy organizations of individuals living with disabilities and other patient advocacy organizations to ensure the transition described in section 1021 takes into account the safety and continuity of care for individuals with disabilities, complex medical needs, or chronic conditions.

SEC. 1023. DEFINITIONS.

In this subtitle, the terms ''health insurance coverage'', ''health insurance issuer'', and ''group health plan'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

TITLE XI—MISCELLANEOUS

SEC. 1101. UPDATING RESOURCE LIMITS FOR SUPPLEMENTAL SECURITY INCOME ELIGIBILITY (SSI).

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

(1) in subparagraph (A)—

(A) by striking ''and'' after ''January 1, 1988,''; and

(B) by inserting '', and to $6,200 on January 1, 2025'' before the period;

(2) in subparagraph (B)—

(A) by striking ''and'' after ''January 1, 1988,''; and

(B) by inserting '', and to $4,100 on January 1, 2025'' before the period; and

(3) by adding at the end the following new subparagraph:

''(C) Beginning with December of 2025, whenever the dollar amounts in effect under paragraphs (1)(A) and (2)(A) of this subsection are increased for a month by a percentage under section 1617(a)(2), each of the dollar amounts in effect under this paragraph shall be increased, effective with such month, by the same percentage (and

rounded, if not a multiple of $10, to the closest multiple of $10). Each increase under this subparagraph shall be based on the unrounded amount for the prior 12-month period.''.

SEC. 1102. DEFINITIONS.

In this Act—

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

(2) the term ''State'' means any of the 50 States, the District of Columbia, or a territory of the United States; and

(3) the term ''United States'' shall include the 50 States, the District of Columbia, and the territories of the United States.