

119TH CONGRESS
1ST SESSION

S. 1506

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

IN THE SENATE OF THE UNITED STATES

APRIL 29, 2025

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

A BILL

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

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

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

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

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

Sec. 1. Short title; table of contents.

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

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

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

- Sec. 201. Comprehensive benefits.
- Sec. 202. No patient cost-sharing.
- Sec. 203. Exclusions and limitations.
- Sec. 204. Continued coverage of institutional long-term care and other services under Medicaid.
- Sec. 205. Prohibiting recovery of correctly paid Medicaid benefits.
- Sec. 206. Additional State standards.

TITLE III—PROVIDER PARTICIPATION

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

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

Subtitle B—Control Over Fraud and Abuse

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

TITLE V—QUALITY OF CARE

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

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

Subtitle A—Budgeting

- Sec. 601. National health budget.
- Sec. 602. Temporary worker assistance.

Subtitle B—Payments to Providers

- Sec. 611. Payments to institutional providers based on global budgets.
- Sec. 612. Payments to individual providers through fee-for-service.
- Sec. 613. Accurate valuation of services under the Medicare physician fee schedule.
- Sec. 614. Payments for prescription drugs and approved devices and equipment.
- Sec. 615. Payment prohibitions; capital expenditures; special projects.
- Sec. 616. Office of Health Equity.
- Sec. 617. Office of Primary Health Care.

TITLE VII—MEDICARE FOR ALL TRUST FUND

- Sec. 701. Medicare for All Trust Fund.

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

- Sec. 801. Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers' compensation.
- Sec. 802. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
- Sec. 803. Effective date of title.

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

- Sec. 901. Relationship to existing Federal health programs.
- Sec. 902. Sunset of provisions related to the Federal and State Exchanges.

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.
- Sec. 1002. Reducing Medicare part D annual out-of-pocket threshold.
- Sec. 1003. Expanding Medicare to cover dental and vision services and hearing aids and examinations under part B.
- Sec. 1004. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
- Sec. 1005. Guaranteed issue of Medigap policies.

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

- Sec. 1011. Lowering the Medicare age.
- Sec. 1012. Establishment of the Medicare transition plan.

Subtitle C—Patient Protections During Medicare for All Transition Period

- Sec. 1021. Minimizing disruptions to patient care.
- Sec. 1022. Public consultation.
- Sec. 1023. Definitions.

TITLE XI—MISCELLANEOUS

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

1 **TITLE I—ESTABLISHMENT OF**
 2 **THE MEDICARE FOR ALL PRO-**
 3 **GRAM; UNIVERSAL ENTITLE-**
 4 **MENT TO BENEFITS; ENROLL-**
 5 **MENT**

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

8 There is hereby established a national health insur-
 9 ance program (referred to in this Act as the “Medicare
 10 for All Program”) to provide comprehensive protection
 11 against the costs of health care and health-related items
 12 and services, in accordance with the standards specified
 13 in, or established under, this Act.

14 **SEC. 102. UNIVERSAL ENTITLEMENT TO BENEFITS.**

15 (a) IN GENERAL.—Every individual who is a resident
 16 of the United States is entitled to benefits for health care
 17 items and services under this Act. The Secretary shall pro-
 18 mulgate a rule that provides criteria for determining resi-
 19 dency for eligibility purposes under this Act.

20 (b) TREATMENT OF OTHER INDIVIDUALS.—The Sec-
 21 retary—

22 (1) may make eligible for benefits for health
 23 care items and services under this Act other individ-
 24 uals not described in subsection (a) and regulate

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

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

8 **SEC. 103. FREEDOM OF CHOICE.**

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

13 **SEC. 104. NON-DISCRIMINATION.**

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

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

5 (b) CLAIMS OF DISCRIMINATION.—

6 (1) IN GENERAL.—The Secretary shall establish
7 a procedure for adjudication of administrative com-
8 plaints alleging a violation of subsection (a).

9 (2) JURISDICTION.—Any person aggrieved by a
10 violation of subsection (a) may file suit in any dis-
11 trict court of the United States having jurisdiction
12 of the parties. A person may bring an action under
13 this paragraph concurrently with such administra-
14 tive remedies as established in paragraph (1).

15 (3) DAMAGES.—If the court finds a violation of
16 subsection (a), the court may grant compensatory
17 and punitive damages (including damages for emo-
18 tional harm), declaratory relief, injunctive relief, at-
19 torneys' fees and costs, or other relief as appro-
20 priate.

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

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

12 **SEC. 105. ENROLLMENT.**

13 (a) IN GENERAL.—The Secretary shall provide a
 14 mechanism for the enrollment of individuals eligible for
 15 benefits under the Medicare for All Program. The mecha-
 16 nism shall—

17 (1) include a process for the automatic enroll-
 18 ment of individuals at the time of birth in the
 19 United States (or upon establishment of residency in
 20 the United States);

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

1 (3) include a process for the enrollment of indi-
 2 viduals made eligible for health care items and serv-
 3 ices under section 102(b).

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

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

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

17 (b) IMMEDIATE COVERAGE OF CHILDREN.—

18 (1) IN GENERAL.—For any eligible individual
 19 under section 102 who has not yet attained the age
 20 of 19 as of the date that is 1 year after the date
 21 of enactment of this Act, benefits shall first be avail-
 22 able under the Medicare for All Program for items
 23 and services furnished on January 1 of the first cal-
 24 endar year that begins after the date of enactment
 25 of this Act.

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

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

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

14 (1) a private health insurer to sell health insur-
 15 ance coverage that duplicates the benefits provided
 16 under the Medicare for All Program; or

17 (2) an employer to provide benefits for an em-
 18 ployee, former employee, or the dependents of an
 19 employee or former employee that duplicate the ben-
 20 efits provided under the Medicare for All Program.

21 (b) CONSTRUCTION.—Nothing in this Act shall be
 22 construed as prohibiting the sale of health insurance cov-
 23 erage for any additional benefits not covered by the Medi-
 24 care for All Program, including additional benefits that

1 an employer may provide to employees or their depend-
2 ents, or to former employees or their dependents.

3 **TITLE II—COMPREHENSIVE BEN-**
4 **EFITS, INCLUDING BENEFITS**
5 **FOR LONG-TERM CARE**

6 **SEC. 201. COMPREHENSIVE BENEFITS.**

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

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

18 (2) Ambulatory patient services.

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

21 (4) Prescription drugs and medical devices, in-
22 cluding outpatient prescription drugs, biological
23 products, and medical devices, and all contraceptive
24 items approved by the Food and Drug Administra-
25 tion.

1 (5) Mental health and substance use treatment
2 services, including inpatient care and treatment for
3 co-occurring mental illness and substance use dis-
4 orders.

5 (6) Laboratory and diagnostic services.

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

9 (8) Comprehensive maternity and newborn care.

10 (9) Comprehensive gender-affirming health
11 care.

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

13 (11) Rehabilitative and habilitative services, in-
14 cluding devices.

15 (12) Emergency services, including transpor-
16 tation.

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

21 (14) Necessary transportation to receive health
22 care items and services for persons with disabilities,
23 older individuals with functional limitations, and
24 low-income individuals (as determined by the Sec-
25 retary).

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

4 (16) Home- and community-based long-term
5 care services and supports (to be provided in accord-
6 ance with the requirements for home and commu-
7 nity-based settings under sections 441.530 and
8 441.710 of title 42, Code of Federal Regulations (as
9 in effect on the date of enactment of this Act), in-
10 cluding—

11 (A) services described in paragraphs (7),
12 (8), (13), (19), and (24) of section 1905(a) of
13 the Social Security Act (42 U.S.C. 1396d(a));

14 (B) home and community-based services
15 described in subsection (c)(4)(B) of section
16 1915 of the Social Security Act (42 U.S.C.
17 1396n) (including habilitation services defined
18 in subsection (c)(5) of such section);

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

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

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

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

7 (b) REVISION.—The Secretary shall, at least on an
8 annual basis, evaluate whether the benefits package should
9 be improved to promote the health of beneficiaries, ac-
10 count for changes in medical practice or new information
11 from medical research, or respond to other relevant devel-
12 opments in health science, and shall make recommenda-
13 tions to Congress regarding any such improvements.

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

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

19 (A) identifying specific complementary and
20 integrative medicine practices that are appro-
21 priate to include in the benefits package; and

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

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

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

5 (B) the Commissioner of Food and Drugs;

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

12 (D) nationally recognized providers of com-
13 plementary and integrative medicine; and

14 (E) such other officials, entities, and indi-
15 viduals with expertise on complementary and
16 integrative medicine as the Secretary deter-
17 mines appropriate.

18 (d) STATES MAY PROVIDE ADDITIONAL BENE-
19 FITS.—Individual States may provide additional benefits
20 for the residents of such States, as determined by such
21 State, and may provide benefits to individuals not eligible
22 for benefits under the Medicare for All Program at the
23 expense of the State.

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

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

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

10 (1) provided that—

11 (A) such schedule is evidence-based, pa-
12 tient-centered, and encourages the use of ge-
13 neric drugs;

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

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

19 (D) such cost-sharing is not imposed on in-
20 dividuals with a household income equal to or
21 below 250 percent of the poverty line for a fam-
22 ily of the size involved; and

23 (2) under which the Secretary may—

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

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

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

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

10 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

11 (a) IN GENERAL.—Benefits for items and services
12 are not available under the Medicare for All Program un-
13 less the items and services meet the standards developed
14 by the Secretary pursuant to section 201(a).

15 (b) TREATMENT OF EXPERIMENTAL ITEMS AND
16 SERVICES.—

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

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

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

5 (c) APPLICATION OF PRACTICE GUIDELINES.—

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

13 (2) CERTAIN EXCEPTIONS.—For purposes of
14 this subsection, an item or service not provided in
15 accordance with a national practice guideline shall
16 be considered to have been provided in accordance
17 with such guideline if the health care provider pro-
18 viding the item or service—

19 (A) exercised appropriate professional dis-
20 cretion to deviate from the guideline in a man-
21 ner authorized or anticipated by the guideline;

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

1 (C) acted in the best interests of the indi-
 2 vidual receiving the item or service; and

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

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

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

11 **“SEC. 1949. STATE PLAN FOR PROVIDING INSTITUTIONAL**
 12 **LONG-TERM CARE SERVICES.**

13 “(a) IN GENERAL.—For quarters beginning on or
 14 after the date on which benefits are first available under
 15 section 106(a) of the Medicare for All Act, notwith-
 16 standing any other provision of this title—

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

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

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

2 or

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

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

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

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

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

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

22 “(5) Nursing facility services described in sec-
23 tion 1905(a)(31).

24 “(c) STATE MAINTENANCE OF EFFORT REQUIRE-
25 MENT.—

1 “(1) ELIGIBILITY STANDARDS.—

2 “(A) IN GENERAL.—Beginning on the date
3 described in subsection (a), no payment may be
4 made under section 1903 with respect to med-
5 ical assistance provided under a State plan for
6 medical assistance if the State adopts income,
7 resource, or other standards and methodologies
8 for purposes of determining an individual’s eli-
9 gibility for medical assistance under the State
10 plan that are more restrictive than those ap-
11 plied as of January 1, 2025.

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

25 “(2) EXPENDITURES.—

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

14 “(B) EXPENDITURE FLOOR.—

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

20 “(I) the amount of the State’s
21 expenditures for fiscal year 2024 on
22 medical assistance for institutional
23 long-term care services; increased by

24 “(II) the growth factor deter-
25 mined under subclause (ii).

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

9 “(I) the percentage increase in
10 health care costs in the State;

11 “(II) the total amount expended
12 by the State for the previous fiscal
13 year on medical assistance for institu-
14 tional long-term care services;

15 “(III) the increase, if any, in the
16 total population of the State from
17 July of 2024 to July of the fiscal year
18 preceding the fiscal year involved;

19 “(IV) the increase, if any, in the
20 population of individuals aged 65 and
21 older of the State from July of 2024
22 to July of the fiscal year preceding
23 the fiscal year involved; and

24 “(V) the decrease, if any, in the
25 population of the State that requires

1 medical assistance for institutional
 2 long-term care services that is attrib-
 3 utable to the availability of coverage
 4 for the services described in section
 5 201(a)(16) of the Medicare for All
 6 Act.

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

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

21 **SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID**
 22 **MEDICAID BENEFITS.**

23 Section 1917 of the Social Security Act (42 U.S.C.
 24 1396p) is amended—

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

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

9 (2) by amending subsection (b) to read as fol-
10 lows:

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

14 **SEC. 206. ADDITIONAL STATE STANDARDS.**

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

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

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

3 **TITLE III—PROVIDER** 4 **PARTICIPATION**

5 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS;** 6 **WHISTLEBLOWER PROTECTIONS.**

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

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

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

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

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

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

1 (A) Items and services to eligible persons
2 shall be furnished by the provider without dis-
3 crimination, in accordance with section 104(a).
4 Nothing in this subparagraph shall be con-
5 strued as requiring the provision of a type or
6 class of items or services that are outside the
7 scope of the provider's normal practice.

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

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

17 (i) quality review;

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

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

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

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

11 (E) In the case of a provider paid under
12 a fee-for-service basis for items and services
13 furnished under the Medicare for All Program,
14 the provider agrees to submit bills and any re-
15 quired supporting documentation relating to the
16 provision of items or services covered under
17 such Program within 30 days after the date of
18 providing such items and services.

19 (F) In the case of an institutional provider
20 paid pursuant to section 611, the provider
21 agrees to submit information and any other re-
22 quired supporting documentation as may be
23 reasonably required by the Secretary within 30
24 days after the date of providing items and serv-
25 ices covered under the Medicare for All Pro-

1 gram and in accordance with the uniform re-
2 porting standards established under section
3 401(b)(1), including information on a quarterly
4 basis that—

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

8 (ii) describes such items and services
9 furnished with respect to specific individ-
10 uals.

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

16 (i) to disclose to the Secretary any
17 system or index of coding or classifying pa-
18 tient symptoms, diagnoses, clinical inter-
19 ventions, episodes, or procedures that such
20 provider utilizes for global budget negotia-
21 tions under title VI or for meeting any
22 other payment, documentation, or data col-
23 lection requirements under this Act; and

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

1 disincentives for health care professionals,
 2 or that is proprietary, interferes with the
 3 medical or nursing process, or is designed
 4 to increase the amount or number of pay-
 5 ments.

6 (H) The provider complies with the duty of
 7 provider ethics and reporting requirements de-
 8 scribed in paragraph (2).

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

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

1 To implement the duty established in this para-
2 graph, the Secretary shall—

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

6 (B) prohibit participating providers,
7 spouses, and immediate family members of par-
8 ticipating providers, from accepting or entering
9 into any arrangement for any bonus, incentive
10 payment, profit-sharing, or compensation based
11 on patient utilization or based on financial out-
12 comes of any other provider or entity; and

13 (C) prohibit participating providers or any
14 board member or representative of such pro-
15 vider from serving as board members for or re-
16 ceiving any compensation, stock, or other finan-
17 cial investment in an entity that contracts with
18 or provides items or services (including pharma-
19 ceutical products and medical devices or equip-
20 ment) to such provider.

21 (3) TERMINATION OF PARTICIPATION AGREE-
22 MENT.—

23 (A) IN GENERAL.—Participation agree-
24 ments may be terminated, with appropriate no-
25 tice—

- 1 (i) by the Secretary for failure to meet
2 the requirements of this Act;
3 (ii) in accordance with the provisions
4 described in section 411; or
5 (iii) by a provider.

6 (B) TERMINATION PROCESS.—Providers
7 shall be provided notice and a reasonable oppor-
8 tunity to correct deficiencies before the Sec-
9 retary terminates an agreement unless a more
10 immediate termination is required for public
11 safety or similar reasons.

12 (C) PROVIDER PROTECTIONS.—

13 (i) PROHIBITION.—The Secretary may
14 not terminate a participation agreement or
15 in any other way discriminate against, or
16 cause to be discriminated against, any par-
17 ticipating provider described in subsection
18 (a) or authorized representative of the pro-
19 vider, on account of such provider or rep-
20 resentative—

21 (I) providing, causing to be pro-
22 vided, or being about to provide or
23 cause to be provided to the provider,
24 the Federal Government, or the attor-
25 ney general of a State information re-

1 lating to any violation of, or any act
 2 or omission the provider or represent-
 3 ative reasonably believes to be a viola-
 4 tion of, any provision of this title;

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

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

11 (IV) objecting to, or refusing to
 12 participate in, any activity, policy,
 13 practice, or assigned task that the
 14 provider or representative reasonably
 15 believes to be in violation of any provi-
 16 sion of this Act (including any amend-
 17 ment made by this Act), or any order,
 18 rule, regulation, standard, or ban
 19 under this Act (including any amend-
 20 ment made by this Act).

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

1 tions, burdens of proof, remedies, and stat-
2 utes of limitation set forth in section 40(b)
3 of the Consumer Product Safety Act (15
4 U.S.C. 2087(b)).

5 (c) WHISTLEBLOWER PROTECTIONS.—

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

10 (A) notified the Secretary or the employ-
11 ee’s employer of any alleged violation of this
12 title, including communications related to car-
13 rying out the employee’s job duties;

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

17 (C) testified before or otherwise provided
18 information relevant for Congress or for any
19 Federal or State proceeding regarding any pro-
20 vision (or proposed provision) of this title;

21 (D) commenced, caused to be commenced,
22 or is about to commence or cause to be com-
23 menced a proceeding under this title;

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

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

6 (2) ENFORCEMENT ACTION.—Any employee
7 covered by this section who alleges discrimination by
8 an employer in violation of paragraph (1) may bring
9 an action, subject to the statute of limitations de-
10 scribed in section 3730(h)(3) of title 31, United
11 States Code, and the rules and procedures, legal
12 burdens of proof, and remedies applicable under sec-
13 tion 31105 of title 49, United States Code.

14 (3) APPLICATION.—

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

1 (B) Nothing in this subsection shall be
2 construed to preempt or diminish any other
3 Federal or State law or regulation against dis-
4 crimination, demotion, discharge, suspension,
5 threats, harassment, reprimand, retaliation, or
6 any other manner of discrimination, including
7 the rights and remedies against retaliatory ac-
8 tion under section 3730(h) of title 31, United
9 States Code.

10 (4) DEFINITIONS.—In this subsection:

11 (A) EMPLOYER.—The term “employer”
12 means any person engaged in profit or a non-
13 profit business or industry, including one or
14 more individuals, partnerships, associations,
15 corporations, trusts, professional membership
16 organizations including a certification, discipli-
17 nary, or other professional body, unincorporated
18 organizations, nongovernmental organizations,
19 or trustees, and subject to liability for violating
20 the provisions of this Act.

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

1 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

2 (a) IN GENERAL.—A health care provider is consid-
3 ered a qualified provider to furnish items and services
4 under the Medicare for All Program if the provider is li-
5 censed or certified to furnish such items and services in
6 the State in which the individual receiving such items and
7 services is located and meets—

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

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

12 (b) FEDERAL PROVIDERS.—Any provider qualified to
13 provide health care items and services at a facility of the
14 Department of Veterans Affairs, the Indian Health Serv-
15 ice, or the uniformed services (as defined in section
16 1072(1) of title 10, United States Code) (with respect to
17 the direct care component of the TRICARE program) is
18 a qualified provider under this section with respect to any
19 individual who qualifies for such items and services under
20 applicable Federal law.

21 (c) MINIMUM PROVIDER STANDARDS.—

22 (1) IN GENERAL.—The Secretary shall estab-
23 lish, evaluate, and update national minimum stand-
24 ards to ensure the quality of items and services pro-
25 vided under the Medicare for All Program and to
26 monitor efforts by States to ensure the quality of

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

5 (2) NATIONAL MINIMUM STANDARDS.—The
6 Secretary shall establish national minimum stand-
7 ards under paragraph (1) for institutional providers
8 of items or services and individual health care prac-
9 titioners. Except as the Secretary may specify in
10 order to carry out this Act, a hospital, skilled nurs-
11 ing facility, or other institutional provider of items
12 or services shall meet standards applicable to such
13 a provider under the Medicare program under title
14 XVIII of the Social Security Act (42 U.S.C. 1395 et
15 seq.). Such standards also may include, where ap-
16 propriate, elements relating to—

17 (A) adequacy and quality of facilities;

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

21 (C) comprehensiveness of items and serv-
22 ices;

23 (D) continuity of items and services;

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

1 (F) performance standards, including orga-
 2 nization, facilities, structure of items and serv-
 3 ices, efficiency of operation, and outcome in
 4 palliation, improvement of health, stabilization,
 5 cure, or rehabilitation.

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

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

14 (a) IN GENERAL.—This section shall apply beginning
 15 on the date on which benefits are first available under sec-
 16 tion 106(a). Subject to the provisions of this section, noth-
 17 ing in this Act shall prohibit an institutional or individual
 18 provider from entering into a private contract with an in-
 19 dividual enrolled for benefits under the Medicare for All
 20 Program for any item or service—

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

23 (2) for which the provider receives—

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

1 (B) receives no amount from an organiza-
 2 tion which receives reimbursement for such
 3 item or service under this Act directly or on a
 4 capitated basis.

5 (b) CONTRACT REQUIREMENTS.—

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

8 (A) be in writing and signed by the indi-
 9 vidual (or authorized representative of the indi-
 10 vidual) receiving the item or service before the
 11 item or service is furnished pursuant to the
 12 contract;

13 (B) be entered into at a time when the in-
 14 dividual is facing an emergency health care sit-
 15 uation; and

16 (C) contain the items described in para-
 17 graph (2).

18 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-
 19 TRACT.—Any contract to provide an item or service
 20 to which subsection (a) applies shall clearly indicate
 21 to the individual that by signing such contract the
 22 individual—

23 (A) agrees not to submit a claim (or to re-
 24 quest that the provider submit a claim) under
 25 this Act for such item or service even if such

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

3 (B) agrees to be responsible, whether
 4 through insurance offered under section 107(b)
 5 or otherwise, for payment of such item or serv-
 6 ice and understands that no reimbursement will
 7 be provided under this Act for such item or
 8 service;

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

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

17 (E) acknowledges that the provider is pro-
 18 viding an item or service outside the scope of
 19 the Medicare for All Program.

20 (c) PROVIDER REQUIREMENTS.—

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

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

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

5 (B) provide that the provider will not sub-
6 mit any claim under this title for any item or
7 service provided to any beneficiary (and will not
8 receive any reimbursement or amount described
9 in subsection (a)(2) for any such item or serv-
10 ice) during the 1-year period beginning on the
11 date the affidavit is signed; and

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

15 (3) ENFORCEMENT.—If a provider signing an
16 affidavit described in paragraph (2) knowingly and
17 willfully submits a claim under this title for any item
18 or service provided during the 1-year period de-
19 scribed in paragraph (2)(B) (or receives any reim-
20 bursement or amount described in subsection (a)(2)
21 for any such item or service) with respect to such af-
22 fidavit—

23 (A) this subsection shall not apply with re-
24 spect to any item or service provided by the
25 provider pursuant to any contract on and after

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

3 (B) no payment shall be made under this
 4 title for any item or service furnished by the
 5 provider during the period described in sub-
 6 paragraph (A) (and no reimbursement or pay-
 7 ment of any amount described in subsection
 8 (a)(2) shall be made for any such item or serv-
 9 ice).

10 **TITLE IV—ADMINISTRATION**
 11 **Subtitle A—General**
 12 **Administration Provisions**

13 **SEC. 401. ADMINISTRATION.**

14 (a) GENERAL DUTIES OF THE SECRETARY.—

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

18 (A) eligibility for benefits under the Medi-
 19 care for All Program;

20 (B) enrollment under such Program;

21 (C) benefits provided under such Program;

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

24 (E) levels of funding;

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

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

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

10 (I) planning for health professional edu-
 11 cation funding;

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

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

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

19 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-
 20 PORT; STUDIES.—

21 (1) UNIFORM REPORTING STANDARDS.—

22 (A) IN GENERAL.—The Secretary shall es-
 23 tablish uniform State reporting requirements,
 24 provider reporting requirements, and national
 25 standards to ensure an adequate national data-

1 base containing information pertaining to
2 health services practitioners, approved pro-
3 viders, the costs of facilities and practitioners
4 providing items and services covered under the
5 Medicare for All Program, the quality of such
6 items and services, the outcomes of such items
7 and services, and the equity of health among
8 population groups. Such database shall include,
9 to the maximum extent feasible without com-
10 promising patient privacy, health outcome
11 measures used under this Act, and to the max-
12 imum extent feasible without excessively bur-
13 dening providers, the measures described in
14 subparagraphs (D) through (F) of subsection
15 (a)(1).

16 (B) REPORTS.—The Secretary shall—

17 (i) regularly analyze information re-
18 ported to the Secretary; and

19 (ii) define rules and procedures to
20 allow researchers, scholars, health care
21 providers, and others to access and analyze
22 data for purposes consistent with quality
23 and outcomes research, without compro-
24 mising patient privacy.

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

6 (A) The status of implementation of this
7 Act.

8 (B) Enrollment under the Medicare for All
9 Program.

10 (C) Benefits under the Medicare for All
11 Program.

12 (D) Expenditures and financing under this
13 Act.

14 (E) Cost-containment measures and
15 achievements under the Medicare for All Pro-
16 gram.

17 (F) Quality assurance.

18 (G) Health care utilization patterns, in-
19 cluding any changes attributable to the Medi-
20 care for All Program.

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

23 (I) Differences in the health status of the
24 populations of the different States, by demo-
25 graphic characteristics, including race, eth-

nicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic 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,

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

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

5 (c) AUDITS.—

6 (1) IN GENERAL.—The Comptroller General of
7 the United States shall conduct an audit of the De-
8 partment of Health and Human Services every fifth
9 fiscal year following the date on which benefits are
10 first available under section 106(a) to determine the
11 effectiveness of the Medicare for All Program in car-
12 rying out the duties under subsection (a).

13 (2) REPORTS.—The Comptroller General of the
14 United States shall submit a report to Congress con-
15 cerning the results of each audit conducted under
16 this subsection.

17 **SEC. 402. CONSULTATION.**

18 The Secretary shall consult with Federal agencies,
19 Indian Tribes and urban Indian health organizations, and
20 private entities, such as labor organizations representing
21 health care workers, professional societies, national asso-
22 ciations, nationally recognized associations of health care
23 experts, medical schools and academic health centers, con-
24 sumer groups, patient advocate groups, disability rights
25 organizations, and labor business organizations in the for-

1 mulation of guidelines, regulations, policy initiatives, and
 2 information gathering to ensure the broadest and most in-
 3 formed input in the administration of this Act. Nothing
 4 in this Act shall prevent the Secretary from adopting
 5 guidelines, consistent with section 203(c), developed by
 6 such a private entity if, in the Secretary's judgment, such
 7 guidelines are generally accepted as reasonable and pru-
 8 dent and consistent with this Act.

9 **SEC. 403. REGIONAL ADMINISTRATION.**

10 (a) REGIONAL MEDICARE FOR ALL OFFICES.—The
 11 Secretary shall establish and maintain regional offices for
 12 the purpose of carrying out the duties specified in sub-
 13 section (c) and promoting adequate access to, and efficient
 14 use of, tertiary care facilities, equipment, items, and serv-
 15 ices by individuals enrolled under the Medicare for All
 16 Program.

17 (b) COORDINATION.—Wherever possible, the Sec-
 18 retary shall incorporate the regional offices and the ad-
 19 ministrative processes of the Centers for Medicare & Med-
 20 icaid Services for the purposes of carrying out subsection
 21 (a).

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

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

3 (2) one deputy director appointed by the re-
4 gional director to represent the Indian and Alaska
5 Native Tribes in the region, if any; and

6 (3) one deputy director appointed by the re-
7 gional director to oversee home- and community-
8 based services and supports.

9 (d) DUTIES.—Each regional director shall—

10 (1) submit an annual regional health care needs
11 assessment report to the Secretary, after a thorough
12 examination of health needs and consultation with
13 public health officials, clinicians, patients, and pa-
14 tient advocates;

15 (2) recommend any changes in provider reim-
16 bursement or payment for delivery of items and
17 services covered under the Medicare for All Program
18 determined appropriate by the regional director, sub-
19 ject to the requirements of title VI; and

20 (3) establish a quality assurance mechanism in
21 each such region in order to minimize both under-
22 utilization and overutilization of health care items
23 and services covered under the Medicare for All Pro-
24 gram and to ensure that all participating providers

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

3 **SEC. 404. BENEFICIARY OMBUDSMAN.**

4 (a) IN GENERAL.—The Secretary shall appoint a
5 Beneficiary Ombudsman who shall have expertise and ex-
6 perience in the fields of health care and education and in
7 providing assistance to individuals entitled to benefits
8 under the Medicare for All Program.

9 (b) DUTIES.—

10 (1) IN GENERAL.—The Beneficiary Ombuds-
11 man shall—

12 (A) receive complaints, grievances, and re-
13 quests for information submitted by individuals
14 entitled to benefits under the Medicare for All
15 Program with respect to any aspect of such
16 Program;

17 (B) provide assistance with respect to com-
18 plaints, grievances, and requests referred to in
19 subparagraph (A), including—

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

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

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

9 (2) AUTHORITIES.—The Ombudsman shall not
10 serve as an advocate for any increases in payments
11 or new coverage of items or services, but may iden-
12 tify issues and problems in payment or coverage
13 policies.

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

15 In performing functions with respect to health per-
16 sonnel education and training, health research, environ-
17 mental health, disability insurance, vocational rehabilita-
18 tion, the regulation of food and drugs, and all other mat-
19 ters pertaining to health, the Secretary shall direct the ac-
20 tivities of the Department of Health and Human Services
21 toward contributions to the health of the people com-
22 plementary to this Act.

1 **Subtitle B—Control Over Fraud**
 2 **and Abuse**

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

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

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

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

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

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

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

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

22 **TITLE V—QUALITY OF CARE**

23 **SEC. 501. QUALITY STANDARDS.**

24 (a) IN GENERAL.—All standards and quality meas-
 25 ures under this Act shall be implemented and evaluated

1 by the Center for Clinical Standards and Quality of the
 2 Centers for Medicare & Medicaid Services (referred to in
 3 this title as the “Center”) or such other agencies deter-
 4 mined appropriate by the Secretary, in coordination with
 5 the Agency for Healthcare Research and Quality and other
 6 offices of the Department of Health and Human Services.

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

9 (1) Review and evaluate each practice guideline
 10 developed under part B of title IX of the Public
 11 Health Service Act (42 U.S.C. 299b et seq.). In so
 12 reviewing and evaluating, the Center shall determine
 13 whether the guideline should be recognized as a na-
 14 tional practice guideline in accordance with and sub-
 15 ject to section 203(c).

16 (2) Review and evaluate each standard of qual-
 17 ity, performance measure, and medical review cri-
 18 terion developed under part B of title IX of the Pub-
 19 lic Health Service Act (42 U.S.C. 299b et seq.). In
 20 so reviewing and evaluating, the Center shall deter-
 21 mine whether the standard, measure, or criterion is
 22 appropriate for use in assessing or reviewing the
 23 quality of items and services provided by health care
 24 institutions or health care professionals. The use of
 25 mechanisms that discriminate against people with

1 disabilities is prohibited for use in any value or cost-
2 effectiveness assessments. The Center shall consider
3 the evidentiary basis for the standard, and the valid-
4 ity, reliability, and feasibility of measuring the
5 standard.

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

9 (4) Development of minimum criteria for com-
10 petence for entities that can qualify to conduct ongo-
11 ing and continuous external quality reviews in the
12 administrative regions. Such criteria shall require
13 such an entity to be administratively independent of
14 the individual or board that administers the region
15 and shall ensure that such entities do not provide fi-
16 nancial incentives to reviewers to favor one pattern
17 of practice over another. The Center shall ensure co-
18 ordination and reporting by such entities to ensure
19 national consistency in quality standards.

20 (5) Submission of a report to the Secretary an-
21 nually specifically on findings from outcomes re-
22 search and development of practice guidelines that
23 may affect the Secretary's determination of coverage
24 of items and services under section 401(a)(1)(G).

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

2 (a) EVALUATING DATA COLLECTION AP-
3 PROACHES.—The Center, in coordination with the Office
4 of Health Equity established under section 1712 of the
5 Public Health Service Act (as added by section 616) and
6 other agencies in the Department of Health and Human
7 Services determined relevant by the Secretary, shall evalu-
8 ate approaches for the collection of data under this Act,
9 to be performed in conjunction with existing quality re-
10 porting requirements and programs under this Act, that
11 allow for the ongoing, accurate, and timely collection of
12 data on disparities in health care items and services and
13 performance on the basis of race, ethnicity, national ori-
14 gin, primary language use, age, disability, sex (including
15 gender identity and sexual orientation), geography, or so-
16 cioeconomic status. In conducting such evaluation, the
17 Center shall consider the following objectives:

18 (1) Protecting patient privacy.

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

22 (3) Improving data on race, ethnicity, national
23 origin, primary language use, age, disability, sex (in-
24 cluding gender identity and sexual orientation), ge-
25 ography, and socioeconomic status.

26 (b) REPORTS TO CONGRESS.—

1 (1) REPORT ON EVALUATION.—Not later than
2 18 months after the date on which benefits are first
3 available under section 106(a), the Center shall sub-
4 mit to Congress and the Secretary a report on the
5 evaluation conducted under subsection (a). Such re-
6 port shall, taking into consideration the results of
7 such evaluation—

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

16 (B) include recommendations on the most
17 effective strategies and approaches to reporting
18 quality measures, as appropriate, on the basis
19 of race, ethnicity, national origin, primary lan-
20 guage use, age, disability, sex (including gender
21 identity and sexual orientation), geography, or
22 socioeconomic status.

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

1 the Center shall submit to Congress and the Sec-
 2 retary a report that includes recommendations for
 3 improving the identification of health care disparities
 4 based on the analyses of data collected under sub-
 5 section (c).

6 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
 7 later than 2 years after the date on which benefits are
 8 first available under section 106(a), the Secretary shall
 9 implement the approaches identified in the report sub-
 10 mitted under subsection (b)(1) for the ongoing, accurate,
 11 and timely collection and evaluation of data on health care
 12 disparities on the basis of race, ethnicity, national origin,
 13 primary language use, age, disability, sex (including gen-
 14 der identity and sexual orientation), geography, or socio-
 15 economic status.

16 **TITLE VI—NATIONAL HEALTH** 17 **BUDGET; PROVIDER PAY-** 18 **MENTS; COST CONTAINMENT** 19 **MEASURES**

20 **Subtitle A—Budgeting**

21 **SEC. 601. NATIONAL HEALTH BUDGET.**

22 (a) NATIONAL HEALTH BUDGET.—

23 (1) IN GENERAL.—Not later than September 1
 24 of each year, beginning with the year prior to the
 25 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

1 All Program to meet the needs of their respec-
2 tive patient populations;

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

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

10 (D) that the health professional education
11 expenditure component described in paragraph
12 (2)(E) is sufficient to provide for the amount of
13 health professional education expenditures suffi-
14 cient to meet the need for items and services
15 covered under the Medicare for All Program.

16 (4) FOR REGIONAL ALLOCATION.—The Sec-
17 retary shall annually provide each regional office
18 with an allotment the Secretary determines appro-
19 priate for purposes of carrying out this Act in such
20 region, including payments to providers in such re-
21 gion, capital expenditures in such region, special
22 projects in such region, health professional education
23 in such region, administrative expenses in such re-
24 gion, and prevention and public health activities in
25 such region.

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

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

5 (B) payments to individual providers pur-
6 suant to section 612.

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

10 (A) the construction or renovation of
11 health care facilities, excluding congregate or
12 segregated facilities for individuals with disabil-
13 ities who receive long-term care services and
14 support; and

15 (B) major equipment purchases.

16 (7) SPECIAL PROJECTS BUDGET.—The special
17 projects budget described in paragraph (2)(C) shall
18 be used for the purposes of allocating funds for the
19 construction of new facilities, major equipment pur-
20 chases, and staffing in rural areas or areas described
21 in section 330(b)(3) of the Public Health Service
22 Act (42 U.S.C. 254b(b)(3)), including areas des-
23 ignated as health professional shortage areas (as de-
24 fined in section 332(a) of the Public Health Service
25 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-

1 cation expenditures” means expenditures in hospitals
 2 and other health care facilities to cover costs associ-
 3 ated with teaching and related research activities, in-
 4 cluding the impact of workforce recruitment, reten-
 5 tion, and diversity on patient outcomes.

6 **SEC. 602. TEMPORARY WORKER ASSISTANCE.**

7 (a) IN GENERAL.—For up to 5 years following the
 8 date on which benefits are first available under section
 9 106(a), at least 1 percent of the national health budget
 10 shall be allocated to programs providing assistance to
 11 workers who perform functions in the administration of
 12 the health insurance system, or related functions within
 13 health care institutions or organizations, who may experi-
 14 ence economic dislocation as a result of the implementa-
 15 tion of this Act.

16 (b) CLARIFICATION.—Assistance described in sub-
 17 section (a) shall include wage replacement, retirement ben-
 18 efits, job training and placement, preferential hiring, and
 19 education benefits.

20 **Subtitle B—Payments to Providers**

21 **SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS**
 22 **BASED ON GLOBAL BUDGETS.**

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

1 independent dialysis facilities) is to furnish items and
2 services under the Medicare for All Program, the Sec-
3 retary shall pay to such institutional provider a lump sum
4 in accordance with the succeeding provisions of this sub-
5 section and consistent with the following:

6 (1) PAYMENT IN FULL.—Such payment shall be
7 considered as payment in full for all operating ex-
8 penses for items and services furnished under the
9 Medicare for All Program, whether inpatient or out-
10 patient, by such provider for such quarter, including
11 outpatient or any other care provided by the institu-
12 tional provider or provided by any health care pro-
13 vider who provided items and services pursuant to
14 an agreement paid through the global budget as de-
15 scribed in paragraph (3).

16 (2) QUARTERLY REVIEW.—The regional direc-
17 tor, on a quarterly basis, shall review whether re-
18 quirements of the institutional provider's participa-
19 tion agreement and negotiated global budget have
20 been performed and shall determine whether adjust-
21 ments to such institutional provider's payment are
22 warranted. This review shall include consideration
23 for additional funding necessary for unanticipated
24 items and services for individuals with complex med-
25 ical needs or market-shift adjustments related to pa-

1 tient volume, and an assessment of any adjustments
2 made to ensure that accuracy and need for adjust-
3 ment was appropriate.

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

6 (A) IN GENERAL.—Certain group practices
7 and other health care providers, as determined
8 by the Secretary, with agreements to provide
9 items and services at a specified institutional
10 provider paid a global budget under this sub-
11 section may elect to be paid through such insti-
12 tutional provider's global budget in lieu of pay-
13 ment under section 612.

14 (B) SALARIES.—Any individual health care
15 professional of such group practice or other
16 provider receiving payment through an institu-
17 tional provider's global budget under this para-
18 graph shall be paid on a salaried basis that is
19 equivalent to salaries or other compensation
20 rates negotiated for individual health care pro-
21 fessionals of such institutional provider.

22 (C) REPORTING AND DISCLOSURE RE-
23 QUIREMENTS.—Any group practice or other
24 health care provider that receives payment
25 through an institutional provider's global budg-

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

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

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

12 (i) natural disasters;

13 (ii) public health emergencies includ-
14 ing outbreaks of epidemics or infectious
15 diseases;

16 (iii) unexpected facility or equipment
17 repairs or purchases;

18 (iv) significant and unexpected in-
19 creases in pharmaceutical or medical device
20 prices; and

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

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

1 (C) Reasonable increases in labor costs, in-
2 cluding salaries and benefits, and changes in
3 collective bargaining agreements, prevailing
4 wages, or local law.

5 (b) PAYMENT AMOUNT.—

6 (1) IN GENERAL.—The amount of each pay-
7 ment to a provider described in subsection (a) shall
8 be determined before the start of each calendar year
9 through negotiations between the provider and the
10 regional director with jurisdiction over such pro-
11 vider. Such amount shall be based on factors speci-
12 fied in paragraph (2).

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

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

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

1 (i) such expenditures for other institu-
2 tional providers in the director's jurisdic-
3 tion; and

4 (ii) normative payment rates estab-
5 lished under comparative payment rate
6 systems, including any adjustments, for
7 such items and services;

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

10 (D) wages for employees, including any
11 necessary increases to ensure mandatory min-
12 imum safe registered nurse-to-patient ratios
13 and optimal staffing levels for physicians and
14 other health care workers;

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

17 (F) education and prevention programs;

18 (G) permissible adjustment to the pro-
19 vider's operating budget due to factors such
20 as—

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

23 (ii) efforts to decrease health care dis-
24 parities in rural areas or areas described in
25 section 330(b)(3) of the Public Health

1 Service Act (42 U.S.C. 254b(b)(3)), in-
 2 cluding areas designated as health profes-
 3 sional shortage areas (as defined in section
 4 332(a) of the Public Health Service Act
 5 (42 U.S.C. 254e(a)));

6 (iii) a response to emergent epidemic
 7 conditions;

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

10 (v) proposed new and innovative pa-
 11 tient care programs at the institutional
 12 level;

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

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

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

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

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

3 (C) exceed the provider's capacity to pro-
 4 vide care under the Medicare for All Program;
 5 or

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

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

19 (5) REGIONAL NEGOTIATIONS PERMITTED.—
 20 Subject to section 614, a regional director may nego-
 21 tiate changes to an institutional provider's global
 22 budget, including any adjustments to address un-
 23 foreseen market shifts related to patient volume.

24 (c) BASELINE RATES AND ADJUSTMENTS.—

1 (1) IN GENERAL.—The Secretary shall use ex-
2 isting prospective payment systems under title
3 XVIII of the Social Security Act (42 U.S.C. 1395 et
4 seq.) to serve as the comparative payment rate sys-
5 tem in global budget negotiations described in sub-
6 section (b). The Secretary shall update such com-
7 parative payment rate systems annually.

8 (2) SPECIFICATIONS.—In developing the com-
9 parative payment rate system, the Secretary shall
10 use only the operating base payment rates under
11 each such prospective payment systems with applica-
12 ble adjustments.

13 (3) LIMITATION.—The comparative rate system
14 established under this subsection shall not include
15 the value-based payment adjustments and the cap-
16 ital expenses base payment rates that may be in-
17 cluded in such a prospective payment system.

18 (4) INITIAL YEAR.—In the first year that global
19 budget payments under this Act are available to in-
20 stitutional providers and for purposes of selecting a
21 comparative payment rate system used during initial
22 global budget negotiations for each institutional pro-
23 vider, the Secretary shall take into account the ap-
24 propriate prospective payment system from the most
25 recent year under title XVIII of the Social Security

1 Act to determine what operating base payment the
2 institutional provider would have been paid for items
3 and services covered under the Medicare for All Pro-
4 gram furnished the preceding year with applicable
5 adjustments, including adjustments due to any pub-
6 lic health emergencies in the preceding year, and ex-
7 cluding value-based payment adjustments, based on
8 such prospective payment system.

9 (d) OPERATING EXPENSES.—For purposes of this
10 title, “operating expenses” of a provider include the fol-
11 lowing:

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

15 (A) Wages and salary costs for physicians,
16 nurses, and other health care practitioners em-
17 ployed by an institutional provider, including
18 mandatory minimum safe registered nurse-to-
19 patient staffing ratios and optimal staffing lev-
20 els for physicians and other health care work-
21 ers.

22 (B) Wages and salary costs for all ancil-
23 lary staff and services.

24 (C) Costs of all pharmaceutical products
25 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.

1 (2) Administrative costs for the institutional
2 provider.

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

5 (a) MEDICARE FOR ALL FEE SCHEDULE.—

6 (1) ESTABLISHMENT.—Not later than 1 year
7 after the date of the enactment of this Act, and in
8 consultation with providers and regional office direc-
9 tors, the Secretary shall establish and annually up-
10 date a national fee schedule that establishes
11 amounts for items and services payable under the
12 Medicare for All Program, furnished by—

13 (A) individual providers;

14 (B) providers in group practices who are
15 not receiving payments on a salaried basis de-
16 scribed in section 611(a)(3);

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

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

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

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

1 security Act and other Federal health programs;
2 and

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

6 (b) LEVERAGING EXISTING MEDICARE PAYMENT
7 PROCESSES.—

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

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

24 (c) APPLICATION OF CURRENT AND PLANNED PAY-
25 MENT REFORMS.—To the extent the Secretary determines

1 such application is necessary to ensure a smooth and fair
 2 transition, the Secretary may apply payment reform ac-
 3 tivities planned or implemented with respect to such title
 4 XVIII as of the date of the enactment of this Act, includ-
 5 ing demonstrations, waivers, or any other provider pay-
 6 ment agreements, to benefits under the Medicare for All
 7 Program, provided that the Secretary sets forth a process
 8 for reviewing such applications and making such deter-
 9 minations that is reasonable, transparent, and docu-
 10 mented, and allows for public comment.

11 (d) PHYSICIAN PRACTICE REVIEW BOARD.—Each di-
 12 rector of a regional office, in consultation with representa-
 13 tives of physicians practicing in that region, shall establish
 14 and appoint a physician practice review board to assure
 15 quality, cost effectiveness, and fair reimbursements for
 16 physician-delivered items and services. The use of mecha-
 17 nisms that discriminate against people with disabilities is
 18 prohibited for use in any value or cost-effectiveness assess-
 19 ments.

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

22 (a) STANDARDIZED AND DOCUMENTED REVIEW
 23 PROCESS.—Section 1848(c)(2) of the Social Security Act
 24 (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the
 25 end the following new subparagraph:

1 “(P) STANDARDIZED AND DOCUMENTED
2 REVIEW PROCESS.—

3 “(i) IN GENERAL.—Not later than one
4 year after the date of enactment of this
5 subparagraph, the Secretary shall estab-
6 lish, document, and make publicly avail-
7 able, in consultation with the Office of Pri-
8 mary Health Care, a standardized process
9 for reviewing the relative values of physi-
10 cians’ services under this paragraph.

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

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

23 “(x) PLANNED AND DOCUMENTED
24 USE OF FUNDS.—For each fiscal year (be-
25 ginning with the first fiscal year beginning

1 on or after the date of enactment of this
2 clause), the Secretary shall provide to Con-
3 gress a written plan for using the funds
4 provided under clause (ix) to collect and
5 use information on physicians' services in
6 the determination of relative values under
7 this subparagraph.”.

8 (c) INTERNAL TRACKING OF REVIEWS.—

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

18 (2) MINIMUM REQUIREMENTS.—The proposal
19 shall include, at a minimum, plans and a timeline
20 for achieving the ability to systematically and inter-
21 nally track the following:

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

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

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

3 (D) When relative values are adjusted.

4 (E) The rationale for final relative value
 5 decisions.

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

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

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

13 (e) CONSULTATION WITH MEDICARE PAYMENT AD-
 14 VISORY COMMISSION.—

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

18 (A) in subparagraph (B)(i), by inserting
 19 “in consultation with the Medicare Payment
 20 Advisory Commission,” after “The Secretary,”;
 21 and

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

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

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

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

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

20 “(Q) PERIODIC AUDIT BY THE COMP-
 21 TROLLER GENERAL.—

22 “(i) IN GENERAL.—The Comptroller
 23 General of the United States (in this sub-
 24 paragraph referred to as the ‘Comptroller
 25 General’) shall periodically audit the review

1 by the Secretary of relative values estab-
 2 lished under this paragraph for physicians'
 3 services.

4 “(ii) ACCESS TO INFORMATION.—The
 5 Comptroller General shall have unre-
 6 stricted access to all deliberations, records,
 7 and data related to the activities carried
 8 out under this paragraph, in a timely man-
 9 ner, upon request.”.

10 **SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
 11 **PROVED DEVICES AND EQUIPMENT.**

12 (a) NEGOTIATED PRICES.—The prices to be paid for
 13 pharmaceutical products, medical supplies, and medically
 14 necessary assistive equipment covered under the Medicare
 15 for All Program shall be negotiated annually by the Sec-
 16 retary.

17 (b) PRESCRIPTION DRUG FORMULARY.—

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

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

1 use of generic medications to the greatest extent
 2 possible.

3 (3) FORMULARY UPDATES AND PETITION
 4 RIGHTS.—The formulary under this subsection shall
 5 be updated frequently and clinicians and patients
 6 may petition the Secretary to add new pharma-
 7 ceuticals or to remove ineffective or dangerous medi-
 8 cations from the formulary.

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

13 **SEC. 615. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**
 14 **TURES; SPECIAL PROJECTS.**

15 (a) PROHIBITIONS.—Payments to participating pro-
 16 viders described in section 301(a) may not take into ac-
 17 count, include any process for the provision of funding for,
 18 or be used by a provider for—

19 (1) marketing of the provider;

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

22 (3) any agreement or arrangement described in
 23 section 203(a)(4) of the Labor-Management Report-
 24 ing and Disclosure Act of 1959 (29 U.S.C.
 25 433(a)(4)); or

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

4 (b) PAYMENTS FOR CAPITAL EXPENDITURES.—

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

14 (2) PRIORITY.—The Secretary shall prioritize
15 allocation of funding under paragraph (1) to
16 projects that propose to use such funds to improve
17 items and services for medically underserved popu-
18 lations and areas described in section 330(b)(3) of
19 the Public Health Service Act (42 U.S.C.
20 254b(b)(3)) or to address health disparities, includ-
21 ing racial, ethnic, national origin, primary language
22 use, age, disability, sex (including gender identity
23 and sexual orientation), geography, or socioeconomic
24 health disparities.

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

10 (4) CAPITAL ASSETS NOT FUNDED BY THE
 11 MEDICARE FOR ALL PROGRAM.—Operating expenses
 12 and funds shall not be used by an institutional pro-
 13 vider receiving payment for capital expenditures
 14 under this subsection for a capital asset that was
 15 not funded by the Medicare for All Program without
 16 the approval of the regional director or directors of
 17 the region or regions where the capital asset is lo-
 18 cated.

19 (c) PROHIBITION AGAINST CO-MINGLING OPER-
 20 ATING AND CAPITAL FUNDS.—Providers that receive pay-
 21 ment under this title shall be prohibited from using, with
 22 respect to funds made available under this Act—

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

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

3 (d) PAYMENTS FOR SPECIAL PROJECTS.—

4 (1) IN GENERAL.—The Secretary shall allocate
5 to each regional director, from amounts made avail-
6 able for special projects pursuant to section
7 601(a)(2)(C), such sums determined appropriate by
8 the Secretary for purposes of funding projects de-
9 scribed in such section, including the construction,
10 renovation, or staffing of health care facilities in
11 rural, underserved, or health professional or medical
12 shortage areas within such region and to address
13 health disparities, including racial, ethnic, national
14 origin, primary language use, age, disability, sex, in-
15 cluding gender identity and sexual orientation, geog-
16 raphy, or socioeconomic health disparities. Each re-
17 gional director shall, prior to distributing such funds
18 in accordance with paragraph (2), present a budget
19 describing how such funds will be distributed to the
20 Secretary.

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

1 (e) PROHIBITION ON FINANCIAL INCENTIVE
 2 METRICS IN PAYMENT DETERMINATIONS.—The Sec-
 3 retary may not utilize any quality metrics or standards
 4 for the purposes of establishing provider payment meth-
 5 odologies, programs, modifiers, or adjustments for pro-
 6 vider payments under this title.

7 **SEC. 616. OFFICE OF HEALTH EQUITY.**

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

11 **“SEC. 1712. OFFICE OF HEALTH EQUITY.**

12 “(a) IN GENERAL.—There is established, in the Of-
 13 fice of the Secretary of Health and Human Services, an
 14 Office of Health Equity, to be headed by a Director, to
 15 ensure coordination and collaboration across the programs
 16 and activities of the Department of Health and Human
 17 Services with respect to ensuring health equity.

18 “(b) MONITORING, TRACKING, AND AVAILABILITY OF
 19 DATA.—

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

24 “(A) the disproportionate burden of dis-
 25 ease and death among people of color,

disaggregated by race, major ethnic group,
 Tribal affiliation, national origin, primary lan-
 guage use, English proficiency status, immigra-
 tion status, length of stay in the United States,
 age, disability, sex (including gender identity
 and sexual orientation), incarceration, home-
 lessness, 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, includ-
 ing—

“(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;

1 “(D) disparities in quality of care received,
 2 including discrimination in health care settings
 3 and the use of racially biased practice guide-
 4 lines and algorithms; and

5 “(E) disparities in utilization of care.

6 “(2) ANALYSIS OF CROSS-SECTIONAL INFORMA-
 7 TION.—The Director of the Office of Health Equity
 8 shall ensure that the data collection and reporting
 9 process under paragraph (1) allows for the analysis
 10 of cross-sectional information on people’s identities.

11 “(c) POLICIES.—In carrying out subsection (a), the
 12 Director of the Office of Health Equity shall develop, co-
 13 ordinate, and promote policies that enhance health equity,
 14 including by—

15 “(1) providing recommendations on—

16 “(A) cultural competence, implicit bias,
 17 and ethics training with respect to health care
 18 workers;

19 “(B) increasing diversity in the health care
 20 workforce; and

21 “(C) ensuring sufficient health care profes-
 22 sionals and facilities; and

23 “(2) ensuring adequate public health funding at
 24 the local and State levels to address health dispari-
 25 ties.

1 “(d) CONSULTATION.—In carrying out subsection
 2 (a), the Director of the Office of Health Equity, in coordi-
 3 nation with the Director of the Indian Health Service,
 4 shall consult with Indian Tribes and with urban Indian
 5 organizations on data collection, reporting, and implemen-
 6 tation of policies.

7 “(e) ANNUAL REPORT.—In carrying out subsection
 8 (a), the Director of the Office of Health Equity shall de-
 9 velop and publish an annual report on—

10 “(1) statistics collected by the Office;

11 “(2) proposed evidence-based solutions to miti-
 12 gate health inequities; and

13 “(3) health care professional staffing levels and
 14 access to facilities.

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

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

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

3 “(2) make such data available for public use
 4 and analysis.

5 “(g) PRIVACY.—Notwithstanding any other Federal
 6 or State law, no Federal or State official or employee or
 7 other entity shall disclose, or use, for any law enforcement
 8 or immigration purpose, any personally identifiable infor-
 9 mation (including with respect to an individual’s religious
 10 beliefs, practices, or affiliation, national origin, ethnicity,
 11 or immigration status) that is collected or maintained pur-
 12 suant to this section.”.

13 **SEC. 617. OFFICE OF PRIMARY HEALTH CARE.**

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

17 **“SEC. 1713. OFFICE OF PRIMARY HEALTH CARE.**

18 “(a) IN GENERAL.—There is established, in the Of-
 19 fice of Health Equity established under section 1712, an
 20 Office of Primary Health Care, to be headed by a Direc-
 21 tor, to ensure coordination and collaboration across the
 22 programs and activities of the Department of Health and
 23 Human Services with respect to increasing access to high-
 24 quality primary health care, particularly in underserved
 25 areas and for underserved populations.

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

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

8 “(2) to address health disparities, including
9 with respect to race, ethnicity, national origin
10 (disaggregated by major ethnic group and Tribal af-
11 filiation), primary language use, English proficiency
12 status, immigration status, length of stay in the
13 United States, age, disability, sex (including gender
14 identity and sexual orientation), incarceration, home-
15 lessness, geography, and socioeconomic status.

16 “(c) OTHER RESPONSIBILITIES.—In carrying out
17 subsections (a) and (b), the Director of the Office of Pri-
18 mary Health Care shall—

19 “(1) coordinate, in consultation with the Sec-
20 retary, health professional education policies and
21 goals to achieve the national goals published pursu-
22 ant to subsection (b);

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

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

3 “(3) develop, coordinate, and promote policies
4 that expand the number of primary health care prac-
5 titioners including primary medical, dental, and be-
6 havioral health care providers, registered nurses, and
7 other advanced practice clinicians;

8 “(4) recommend appropriate workforce train-
9 ing, technical assistance, and patient protection en-
10 hancements for primary health care practitioners, in-
11 cluding registered nurses, to achieve uniform high
12 quality and patient safety;

13 “(5) provide recommendations on targeted pro-
14 grams and resources for Federally qualified health
15 centers, community health centers, rural health cen-
16 ters, behavioral health clinics, and other community-
17 based organizations;

18 “(6) provide recommendations for broader pa-
19 tient referral to additional resources, not limited to
20 health care, and collaboration with other organiza-
21 tions and sectors that influence health outcomes;
22 and

23 “(7) consult with the Secretary on the alloca-
24 tion of the special projects budget under section
25 601(a)(2)(C) of the Medicare for All Act.

1 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed—

3 “(1) to preempt any provision of State law es-
4 tablishing practice standards or guidelines for health
5 care professionals, including professional licensing or
6 practice laws or regulations; or

7 “(2) to require that any State impose additional
8 educational standards or guidelines for health care
9 professionals.”.

10 **TITLE VII—MEDICARE FOR ALL** 11 **TRUST FUND**

12 **SEC. 701. MEDICARE FOR ALL TRUST FUND.**

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

20 (b) APPROPRIATIONS INTO TRUST FUND.—

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

1 amounts equivalent to 100 percent of the net in-
2 crease in revenues to the Treasury which is attrib-
3 utable to the amendments made by section 801 and
4 section 902. The amounts appropriated by the pre-
5 ceding sentence shall be transferred from time to
6 time (but not less frequently than monthly) from the
7 general fund in the Treasury to the Trust Fund,
8 such amounts to be determined on the basis of esti-
9 mates by the Secretary of the Treasury of the taxes
10 paid to or deposited into the Treasury, and proper
11 adjustments shall be made in amounts subsequently
12 transferred to the extent prior estimates were in ex-
13 cess of or were less than the amounts that should
14 have been so transferred.

15 (2) CURRENT PROGRAM RECEIPTS.—

16 (A) INITIAL YEAR.—Notwithstanding any
17 other provision of law, there is hereby appro-
18 priated to the Trust Fund for the first fiscal
19 year beginning at least one year after the date
20 of the enactment of this Act, an amount equal
21 to the aggregate amount appropriated for the
22 preceding fiscal year for the following (in-
23 creased by the consumer price index for all
24 urban consumers for the fiscal year involved):

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

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

9 (iii) The Federal Employees Health
10 Benefits program, under chapter 89 of title
11 5, United States Code.

12 (iv) The maternal and child health
13 program (under title V of the Social Secu-
14 rity Act (42 U.S.C. 701 et seq.)), voca-
15 tional rehabilitation programs, programs
16 for drug abuse and mental health services
17 under the Public Health Service Act, pro-
18 grams providing general hospital or med-
19 ical assistance, and any other Federal pro-
20 gram identified by the Secretary, in con-
21 sultation with the Secretary of the Treas-
22 ury, to the extent the programs provide for
23 payment for health care items and services
24 the payment of which may be made under
25 this Act.

1 (B) SUBSEQUENT YEARS.—Notwith-
2 standing any other provision of law, there is ap-
3 propriated to the Trust Fund for each fiscal
4 year following the fiscal year in which the ap-
5 propriation is made under subparagraph (A),
6 an amount equal to the amount appropriated to
7 the Trust Fund for the previous year, adjusted
8 for reductions in costs resulting from the imple-
9 mentation of this Act, changes in the consumer
10 price index for all urban consumers for the fis-
11 cal year involved, and other factors determined
12 appropriate by the Secretary.

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

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

1 of Trustees of the Trust Fund” or the “Board of Trust-
 2 ees” shall mean the “Secretary”.

3 (d) TRANSFER OF FUNDS.—Any amounts remaining
 4 in the Federal Hospital Insurance Trust Fund under sec-
 5 tion 1817 of the Social Security Act (42 U.S.C. 1395i)
 6 or the Federal Supplementary Medical Insurance Trust
 7 Fund under section 1841 of such Act (42 U.S.C. 1395t)
 8 after the payment of claims for items and services fur-
 9 nished under title XVIII of such Act have been completed,
 10 shall be transferred into the Medicare for All Trust Fund
 11 under this section.

12 **TITLE VIII—CONFORMING**
 13 **AMENDMENTS TO THE EM-**
 14 **PLOYEE RETIREMENT IN-**
 15 **COME SECURITY ACT OF 1974**

16 **SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**
 17 **TIVE OF BENEFITS UNDER THE MEDICARE**
 18 **FOR ALL PROGRAM; COORDINATION IN CASE**
 19 **OF WORKERS’ COMPENSATION.**

20 (a) IN GENERAL.—Part 5 of subtitle B of title I of
 21 the Employee Retirement Income Security Act of 1974
 22 (29 U.S.C. 1131 et seq.) is amended by adding at the end
 23 the following new section:

1 **“SEC. 524. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**
2 **CATIVE OF MEDICARE FOR ALL PROGRAM**
3 **BENEFITS; COORDINATION IN CASE OF**
4 **WORKERS’ COMPENSATION.**

5 “(a) IN GENERAL.—Subject to subsection (b), no em-
6 ployee benefit plan may provide benefits that duplicate
7 payment for any items or services for which payment may
8 be made under the Medicare for All Program established
9 under section 101 of the Medicare for All Act (referred
10 to in this section as the ‘Medicare for All Program’).

11 “(b) REIMBURSEMENT.—Each workers compensation
12 carrier that is liable for payment for workers compensa-
13 tion services furnished in a State shall reimburse the
14 Medicare for All Program for the cost of such services.

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

16 “(1) the term ‘workers compensation carrier’
17 means an insurance company that underwrites work-
18 ers compensation medical benefits with respect to
19 one or more employers and includes an employer or
20 fund that is financially at risk for the provision of
21 workers compensation medical benefits;

22 “(2) the term ‘workers compensation medical
23 benefits’ means, with respect to an enrollee who is
24 an employee subject to the workers compensation
25 laws of a State, the comprehensive medical benefits
26 for work-related injuries and illnesses provided for

1 under such laws with respect to such an employee;
 2 and

3 “(3) the term ‘workers compensation services’
 4 means items and services included in workers com-
 5 pensation medical benefits and includes items and
 6 services (including rehabilitation items and services
 7 and long-term care items and services) commonly
 8 used for treatment of work-related injuries and ill-
 9 nesses.”.

10 (b) CONFORMING AMENDMENT.—Section 4(b) of the
 11 Employee Retirement Income Security Act of 1974 (29
 12 U.S.C. 1003(b)) is amended by adding at the end the fol-
 13 lowing: “Paragraph (3) shall apply subject to section
 14 524(b) (relating to reimbursement of the Medicare for All
 15 Program by workers compensation carriers).”.

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

“Sec. 524. Prohibition of employee benefits duplicative of Medicare for All Pro-
 gram benefits; coordination in case of workers’ compensation.”.

1 **SEC. 802. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
2 **MENTS UNDER ERISA AND CERTAIN OTHER**
3 **REQUIREMENTS RELATING TO GROUP**
4 **HEALTH PLANS.**

5 (a) IN GENERAL.—Part 6 of subtitle B of title I of
6 the Employee Retirement Income Security Act of 1974
7 (29 U.S.C. 1161 et seq.) is repealed.

8 (b) CONFORMING AMENDMENTS.—

9 (1) Section 502(a) of such Act (29 U.S.C.
10 1132(a)) is amended—

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

12 (B) by redesignating paragraphs (8), (9),
13 and (10) as paragraphs (7), (8), and (9), re-
14 spectively.

15 (2) Section 502(c)(1) of such Act (29 U.S.C.
16 1132(c)(1)) is amended by striking “paragraph (1)
17 or (4) of section 606,”.

18 (3) Section 502(e) of such Act (29 U.S.C.
19 1132(e)) is amended by striking “paragraphs (1)(B)
20 and (7)” and inserting “paragraph (1)(B)”.

21 (4) Section 502(l)(3)(B) of such Act (29 U.S.C.
22 1132(l)(3)(B)) is amended by striking “subsection
23 (a)(9)” and inserting “subsection (a)(8)”.

24 (5) Section 514(b) of such Act (29 U.S.C.
25 1144(b)) is amended—

1 (A) in paragraph (7), by striking “section
2 206(d)(3)(B)(i),”; and

3 (B) by striking paragraph (8).

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

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

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

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

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

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

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

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

1 which benefits are first available under section
2 106(a);

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

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

13 (D) no payment shall be made to a State
14 under section 1903(a) or 2105(a) of such Act
15 (42 U.S.C. 1396b(a); 42 U.S.C. 1397ee) with
16 respect to medical assistance or child health as-
17 sistance for any item or service furnished on or
18 after such date.

19 (2) TRANSITION.—In the case of inpatient hos-
20 pital services and extended care services during a
21 continuous period of stay which began before the
22 date on which benefits are first available under sec-
23 tion 106(a), and which had not ended as of such
24 date, for which benefits are provided under title
25 XVIII of the Social Security Act, under a State plan

1 under title XIX of such Act, or under a State child
 2 health plan under title XXI of such Act, the Sec-
 3 retary shall provide for continuation of benefits
 4 under such title or plan until the end of the period
 5 of stay.

6 (3) CONTINUED COVERAGE OF LONG-TERM
 7 CARE AND OTHER CERTAIN SERVICES UNDER MED-
 8 ICAID.—

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

13 (i) institutional long-term care serv-
 14 ices (as defined in section 1948(b) of such
 15 Act); or

16 (ii) any other service for which bene-
 17 fits are not available under the Medicare
 18 for All Program and which is furnished
 19 under a State plan under title XIX of the
 20 Social Security Act which provided for
 21 medical assistance for such service on Jan-
 22 uary 1, 2023.

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

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

3 (i) identify items and services de-
4 scribed in subparagraph (A)(ii) with re-
5 spect to each State plan; and

6 (ii) ensure that such items and serv-
7 ices continue to be made available under
8 such plan.

9 (C) STATE MAINTENANCE OF EFFORT RE-
10 QUIREMENT.—With respect to any service de-
11 scribed in subparagraph (A)(ii) that is made
12 available under a State plan under title XIX of
13 the Social Security Act, the maintenance of ef-
14 fort requirements described in section 1948(c)
15 of such Act (related to eligibility standards and
16 required expenditures) shall apply to such serv-
17 ice in the same manner that such requirements
18 apply to institutional long-term care services (as
19 defined in section 1948(b) of such Act).

20 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
21 GRAM.—No benefits shall be made available under chapter
22 89 of title 5, United States Code, with respect to items
23 and services furnished to any individual eligible to enroll
24 under the Medicare for All Program.

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

3 (1) IN GENERAL.—Nothing in this Act shall af-
4 fect the eligibility of veterans for the medical bene-
5 fits and services provided under title 38, United
6 States Code, the eligibility of individuals for
7 TRICARE medical benefits and services provided
8 under sections 1079 and 1086 of title 10, United
9 States Code, or of Indians for the medical benefits
10 and services provided by or through the Indian
11 Health Service.

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

15 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE FED-**
16 **ERAL AND STATE EXCHANGES.**

17 Effective on the date on which benefits are first avail-
18 able under section 106(a), the Federal and State Ex-
19 changes established pursuant to title I of the Patient Pro-
20 tection and Affordable Care Act (Public Law 111–148)
21 shall terminate, and any other provision of law that relies
22 upon participation in or enrollment through such an Ex-
23 change, including such provisions of the Internal Revenue
24 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 indi-
vidual 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 ex-
ceeds \$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 “(1) IN GENERAL.—Subject to paragraphs (2)
2 and (3), in this section, the term ‘out-of-pocket cost-
3 sharing’ means, with respect to an individual, the
4 amount of the expenses incurred by the individual
5 that are attributable to—

6 “(A) coinsurance and copayments applica-
7 ble under part A or B; or

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

11 “(2) CERTAIN COSTS NOT INCLUDED.—

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

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

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

1 or service was furnished on an assignment-re-
 2 lated basis shall not be considered incurred ex-
 3 penses for purposes of determining out-of-pock-
 4 et cost-sharing under paragraph (1).

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

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

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

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

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

23 (A) by striking “and for a subsequent
 24 year” and inserting “for each of 2006 through

1 the year that includes the date of enactment of
 2 the Medicare for All Act”; and

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

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

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

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

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

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

16 “(I) IN GENERAL.—Subject to
 17 subclause (II), for plan years begin-
 18 ning on or after January 1 following
 19 the date of enactment of the Medicare
 20 for All Act and before January 1 of
 21 the year that is 4 years following such
 22 date of enactment, notwithstanding
 23 clauses (i) and (ii), the ‘annual out-of-
 24 pocket threshold’ specified in this sub-
 25 paragraph is equal to \$300.

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

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

13 (a) DENTAL SERVICES.—

14 (1) REMOVAL OF EXCLUSION FROM COV-
 15 ERAGE.—Section 1862(a) of the Social Security Act
 16 (42 U.S.C. 1395y(a)) is amended by striking para-
 17 graph (12).

18 (2) COVERAGE.—

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

22 (i) in subparagraph (JJ), by inserting
 23 “and” at the end; and

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

1 “(KK) dental services;”.

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

5 (i) by striking “and” before “(HH)”;

6 and

7 (ii) by inserting before the semicolon
8 at the end the following: “and (II) with re-
9 spect to dental services described in section
10 1861(s)(2)(KK), the amount paid shall be
11 an amount equal to 80 percent of the less-
12 er of the actual charge for the services or
13 the amount determined under the fee
14 schedule established under section
15 1848(b).”.

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

20 (b) VISION SERVICES.—

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

24 (A) in subparagraph (JJ), by striking
25 “and” at the end;

1 (B) in subparagraph (KK), by inserting
 2 “and” at the end; and

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

5 “(LL) vision services;”.

6 (2) PAYMENT.—Section 1833(a)(1) of the So-
 7 cial Security Act (42 U.S.C. 1395l(a)(1)), as amend-
 8 ed by subsection (a), is amended—

9 (A) by striking “and” before “(II)”; and

10 (B) by inserting before the semicolon at
 11 the end the following: “, and (JJ) with respect
 12 to vision services described in section
 13 1861(s)(2)(LL), the amount paid shall be an
 14 amount equal to 80 percent of the lesser of the
 15 actual charge for the services or the amount de-
 16 termined under the fee schedule established
 17 under section 1848(b).”.

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

22 (c) HEARING AIDS AND EXAMINATIONS THERE-
 23 FOR.—

24 (1) IN GENERAL.—Section 1862(a)(7) of the
 25 Social Security Act (42 U.S.C. 1395y(a)(7)) is

1 amended by striking “hearing aids or examinations
2 therefor,”.

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

7 **SEC. 1004. ELIMINATING THE 24-MONTH WAITING PERIOD**
8 **FOR MEDICARE COVERAGE FOR INDIVID-**
9 **UALS WITH DISABILITIES.**

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

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

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

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

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

1 month following the month in which the individual
 2 meets the requirements of such paragraph, and”;
 3 and

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

7 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

22 (4) RAILROAD RETIREMENT SYSTEM.—Section
 23 7(d)(2)(ii) of the Railroad Retirement Act of 1974
 24 (45 U.S.C. 231f(d)(2)(ii)) is amended—

1 (A) by striking “has been entitled to an
2 annuity” and inserting “is entitled to an annu-
3 ity”;

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

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

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

15 **SEC. 1005. GUARANTEED ISSUE OF MEDIGAP POLICIES.**

16 Section 1882 of the Social Security Act (42 U.S.C.
17 1395ss) is amended by adding at the end the following
18 new subsection:

19 “(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELI-
20 GIBLE MEDICARE BENEFICIARIES.—Notwithstanding
21 paragraphs (2)(A) and (2)(D) of subsection (s) or any
22 other provision of this section, on or after the date of en-
23 actment of this subsection, the issuer of a Medicare sup-
24 plemental policy may not deny or condition the issuance
25 or effectiveness of a Medicare supplemental policy, or dis-

1 criminate in the pricing of the policy, because of health
 2 status, claims experience, receipt of health care, or medical
 3 condition in the case of any individual entitled to, or en-
 4 rolled for, benefits under part A and enrolled for benefits
 5 under part B.”.

6 **Subtitle B—Temporary Medicare**
 7 **Buy-In Option and Temporary**
 8 **Public Option**

9 **SEC. 1011. LOWERING THE MEDICARE AGE.**

10 (a) IN GENERAL.—Title XVIII of the Social Security
 11 Act (42 U.S.C. 1395c et seq.), as amended by section
 12 1001, is amended by adding at the end the following new
 13 section:

14 “TEMPORARY MEDICARE BUY-IN OPTION FOR CERTAIN
 15 INDIVIDUALS

16 “SEC. 1899D. (a) NO EFFECT ON OTHER BENEFITS
 17 FOR INDIVIDUALS OTHERWISE ELIGIBLE OR ON TRUST
 18 FUNDS.—The Secretary shall implement the provisions of
 19 this section in such a manner to ensure that such provi-
 20 sions—

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

25 “(2) have no negative impact on the Federal
 26 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.

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

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

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

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

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

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

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

1 “(d) PREMIUM.—

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

12 “(2) ANNUAL PREMIUM.—

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

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

1 “(3) INCREASED PREMIUM FOR COMPLEMEN-
 2 TARY PLANS.—Nothing in this section shall preclude
 3 an individual from choosing a prescription drug plan
 4 or other complementary plans which requires the in-
 5 dividual to pay an additional amount (because of
 6 supplemental benefits or because it is a more expen-
 7 sive plan). In such case the individual would be re-
 8 sponsible for the increased monthly premium.

9 “(e) PAYMENT OF PREMIUMS.—

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

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

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

1 “(g) TREATMENT IN RELATION TO THE AFFORD-
2 ABLE CARE ACT.—

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

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

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

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

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

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

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

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

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

10 “(h) CONSULTATION.—In promulgating regulations
11 to implement this section, the Secretary shall consult with
12 interested parties, including groups representing bene-
13 ficiaries, health care providers, employers, and insurance
14 companies.”.

15 **SEC. 1012. ESTABLISHMENT OF THE MEDICARE TRANSI-**
16 **TION PLAN.**

17 (a) IN GENERAL.—To carry out the purpose of this
18 section, for plan years beginning with the first plan year
19 that begins after the date of enactment of this Act and
20 ending with the date on which benefits are first available
21 under section 106(a), the Secretary, acting through the
22 Administrator of the Centers for Medicare & Medicaid (re-
23 ferred to in this section as the “Administrator”), shall es-
24 tablish, and provide for the offering through the Ex-
25 changes, of a public health plan (in this Act referred to

1 as the “Medicare Transition plan”) that provides afford-
 2 able, high-quality health benefits coverage throughout the
 3 United States.

4 (b) ADMINISTERING THE MEDICARE TRANSI-
 5 TION.—

6 (1) ADMINISTRATOR.—The Administrator shall
 7 administer the Medicare Transition plan in accord-
 8 ance with this section.

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

18 (3) OFFERING THROUGH EXCHANGES.—The
 19 Medicare Transition plan shall be made available
 20 only through the Exchanges, and shall be available
 21 to individuals wishing to enroll and to qualified em-
 22 ployers (as defined in section 1312(f)(2) of the Pa-
 23 tient Protection and Affordable Care Act (42 U.S.C.
 24 18032(f)(2))) who wish to make such plan available
 25 to their employees.

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

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

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

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

12 (d) PROVIDERS AND REIMBURSEMENT RATES.—

13 (1) IN GENERAL.—With respect to the reim-
 14 bursement provided to health care providers for cov-
 15 ered benefits, as described in section 201, provided
 16 under the Medicare Transition plan, the Adminis-
 17 trator shall reimburse such providers at rates deter-
 18 mined for equivalent items and services under the
 19 original Medicare fee-for-service program under
 20 parts A and B of title XVIII of the Social Security
 21 Act (42 U.S.C. 1395c et seq.). For items and serv-
 22 ices covered under the Medicare Transition plan but
 23 not covered under such parts A and B, the Adminis-
 24 trator shall reimburse providers at rates set by the
 25 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

1 U.S.C. 1395 et seq.) or under a State Medicaid
 2 plan under title XIX of such Act (42 U.S.C.
 3 1396 et seq.) on the date of enactment of this
 4 Act shall be a participating provider in the
 5 Medicare Transition plan.

6 (B) ADDITIONAL PROVIDERS.—The Ad-
 7 ministrator shall establish a process to allow
 8 health care providers not described in subpara-
 9 graph (A) to become participating providers in
 10 the Medicare Transition plan. Such process
 11 shall be similar to the process applied to new
 12 providers under the Medicare program.

13 (e) PREMIUMS.—

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

17 (A) may vary according to family or indi-
 18 vidual coverage, age, and tobacco status (con-
 19 sistent with clauses (i), (iii), and (iv) of section
 20 2701(a)(1)(A) of the Public Health Service Act
 21 (42 U.S.C. 300gg(a)(1)(A))); and

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

1 fordable Care Act (42 U.S.C. 18071) and sec-
 2 tion 36B of the Internal Revenue Code of 1986,
 3 as amended by subsection (g).

4 (2) LIMITATION.—Variation in premium rates
 5 of the Medicare Transition plan by rating area, as
 6 described in clause (ii) of section 2701(a)(1)(A)(iii)
 7 of the Public Health Service Act (42 U.S.C.
 8 300gg(a)(1)(A)) is not permitted.

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

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

13 (1) PREMIUM ASSISTANCE TAX CREDITS.—

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

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

1 “(i) IN GENERAL.—In the case of a
 2 taxpayer who is covered, or whose spouse
 3 or dependent (as defined in section 152) is
 4 covered, by the Medicare Transition plan
 5 established under section 1012(a) of the
 6 Medicare for All Act for all months in the
 7 taxable year, subparagraph (A) shall be
 8 applied without regard to ‘but does not ex-
 9 ceed 400 percent’. The preceding sentence
 10 shall not apply to any taxable year to
 11 which subparagraph (E) applies.

12 “(ii) ENROLLEES IN MEDICAID NON-
 13 EXPANSION STATES.—In the case of a tax-
 14 payer residing in a State which (as of the
 15 date of the enactment of the Medicare for
 16 All Act) does not provide for eligibility
 17 under clause (i)(VIII) or (ii)(XX) of sec-
 18 tion 1902(a)(10)(A) of the Social Security
 19 Act for medical assistance under title XIX
 20 of such Act (or a waiver of the State plan
 21 approved under section 1115) who is cov-
 22 ered, or whose spouse or dependent (as de-
 23 fined in section 152) is covered, by the
 24 Medicare Transition plan established under
 25 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)”;

(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

1 for all months in the taxable year the ap-
 2 plicable percentage for any taxable year
 3 shall be determined in the same manner as
 4 under clause (i), except that the following
 5 table shall apply in lieu of the table con-
 6 tained 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.

7 The preceding sentence shall not apply to
 8 any taxable year to which clause (iv) ap-
 9 plies.”.

10 (ii) CONFORMING AMENDMENTS.—

11 (I) Subclause (I) of clause (iii) of
 12 section 36B(b)(3)(A) of such Code, as
 13 redesignated by subparagraph (A)(i),
 14 is amended by inserting “, and deter-
 15 mined after the application of clause
 16 (ii)” after “after application of this
 17 clause”.

18 (II) Section 36B(b)(3)(A)(iv)(I)
 19 of such Code, as redesignated by sub-
 20 paragraph (A)(i), is amended by strik-

1 ing “clause (ii)” and inserting “clause
2 (iii)”.

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

7 (A) by inserting “, or in the Medicare
8 Transition plan established under section
9 1012(a) of the Medicare for All Act,” after
10 “coverage” in paragraph (1);

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

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

18 (D) by striking the flush language; and

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

21 “(2) SPECIAL RULES.—

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

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

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

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

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

(h) CONFORMING AMENDMENTS.—

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

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

(B) by inserting “the Medicare Transition plan 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”.

1 **Subtitle C—Patient Protections**
2 **During Medicare for All Transi-**
3 **tion Period**

4 **SEC. 1021. MINIMIZING DISRUPTIONS TO PATIENT CARE.**

5 The Secretary shall ensure that all individuals en-
6 rolled in, or who seek to enroll in, a group health plan,
7 health insurance coverage offered by a health insurance
8 issuer, or the plan established under section 1012 during
9 the transition period of this Act are protected from disrup-
10 tions in their care during the transition period.

11 **SEC. 1022. PUBLIC CONSULTATION.**

12 The Secretary shall consult with communities and ad-
13 vocacy organizations of individuals living with disabilities
14 and other patient advocacy organizations to ensure the
15 transition described in section 1021 takes into account the
16 safety and continuity of care for individuals with disabil-
17 ities, complex medical needs, or chronic conditions.

18 **SEC. 1023. DEFINITIONS.**

19 In this subtitle, the terms “health insurance cov-
20 erage”, “health insurance issuer”, and “group health
21 plan” have the meanings given such terms in section 2791
22 of the Public Health Service Act (42 U.S.C. 300gg–91).

1 **TITLE XI—MISCELLANEOUS**

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

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

7 (1) in subparagraph (A)—

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

10 (B) by inserting “, and to \$6,200 on Janu-
 11 ary 1, 2025” before the period;

12 (2) in subparagraph (B)—

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

15 (B) by inserting “, and to \$4,100 on Janu-
 16 ary 1, 2025” before the period; and

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

19 “(C) Beginning with December of 2025, when-
 20 ever the dollar amounts in effect under paragraphs
 21 (1)(A) and (2)(A) of this subsection are increased
 22 for a month by a percentage under section
 23 1617(a)(2), each of the dollar amounts in effect
 24 under this paragraph shall be increased, effective
 25 with such month, by the same percentage (and

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

5 **SEC. 1102. DEFINITIONS.**

6 In this Act—

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

9 (2) the term “State” means any of the 50
10 States, the District of Columbia, or a territory of the
11 United States; and

12 (3) the term “United States” shall include the
13 50 States, the District of Columbia, and the terri-
14 tories of the United States.

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