II

116TH CONGRESS
1ST SESSION

S. 1129

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

IN THE SENATE OF THE UNITED STATES

APRIL 10, 2019

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

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act of 2019''.

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

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

SEC. 101. ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM.

There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL ENTITLEMENT.

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

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

(1) may make eligible for benefits for health care services under this Act other individuals not described in subsection (a) and regulate their eligibility to ensure that every person in the United States has access to health care; and

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

SEC. 103. FREEDOM OF CHOICE.

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

SEC. 104. NON-DISCRIMINATION.

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

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

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

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

SEC. 105. ENROLLMENT.

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

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

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

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

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

under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

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

(b) COVERAGE FOR CHILDREN.—

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

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

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

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

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

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or

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

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

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

SEC. 201. COMPREHENSIVE BENEFITS.

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

benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

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

(2) Ambulatory patient services.

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

(4) Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products.

(5) Mental health and substance abuse treatment services, including inpatient care.

(6) Laboratory and diagnostic services.

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

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

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

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

(11) Emergency services and transportation.

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

(13) Home and community-based long-term services and supports (to be provided in accordance with the requirements for home and community-based settings under sections 441.530 and 441.710 of title 42, Code of Federal Regulations), including—

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

(B) home and community-based services described in subsection (c)(4)(B) of section 1915 of the Social Security Act (including habilitation services defined in subsection (c)(5) of such section);

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

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

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

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

(c) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

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

(A) identifying specific complementary and integrative medicine practices that, on the basis of research findings or promising clinical interventions, are appropriate to include in the benefits package; and

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

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

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

(B) the Commissioner of Food and Drugs;

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

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

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

(d) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States at the expense of the State.

SEC. 202. NO COST-SHARING.

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

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

(1) provided that—

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

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

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

(D) such cost-sharing is not imposed on individuals with a household income equal to or below 200 percent of the poverty line for a family of the size involved; and

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

(c) NO BALANCE BILLING.—Notwithstanding contracts in accordance with section 303, no provider may impose a charge to an enrolled individual for covered services for which benefits are provided under this Act.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

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

(b) TREATMENT OF EXPERIMENTAL SERVICES AND DRUGS.—

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

(2) APPEALS PROCESS.—The Secretary shall establish a process by which individuals can appeal coverage decisions. The process shall, as much as is feasible, follow process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

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

Human Services has recognized a national practice guideline, the services are considered to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline. For purposes of this subsection, a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

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

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

''STATE PLAN FOR PROVIDING INSTITUTIONAL LONG-TERM CARE SERVICES

''SEC. 1947. (a) IN GENERAL.—For quarters beginning on or after date on which benefits are first available under section 106(a) of the Medicare for All Act of 2019, notwithstanding any other provision of this title—

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

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

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

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

"(B) other services for which benefits are not available under the Medicare for All Act of 2019 and which are furnished under a State plan for medical assistance which provided for medical assistance for such services on September 1, 2018.

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

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

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

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

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

''(5) Nursing facility services described in section 1905(a)(29).

''(c) MAINTENANCE OF EFFORT.—

''(1) ELIGIBILITY STANDARDS.—

''(A) IN GENERAL.—Beginning on the date described in subsection (a), no payment may be made under section 1903 with respect to medical assistance provided under a State plan for medical assistance if the State adopts income, resource, or other standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan that are more restrictive than those applied as of January 1, 2019.

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

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

''(2) EXPENDITURES.—

''(A) IN GENERAL.—For each fiscal year or portion of a fiscal year that occurs during the period that begins on the first day of the first fiscal quarter that begins on or after the date on which benefits are first available under section 106(a) of the Medicare for All Act of 2019, as a condition of receiving payments under section 1903(a), a State shall make expenditures for medical assistance for services that are institutional long-term care services in an amount that is not less than the expenditure floor determined for the State and fiscal year (or portion of a fiscal year) under subparagraph (B).

''(B) EXPENDITURE FLOOR.—

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

''(I) the amount of the State's expenditures for fiscal year 2018 on

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

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

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

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

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

"(III) the increase, if any, in the total population of the State from July of 2018 to July of the fiscal year preceding the fiscal year involved;

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

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

''(V) the decrease, if any, in the population of the State that requires medical assistance for institutional long-term care services that is attributable to the availability of coverage for the services described in section 201(a)(13) of the Medicare for All Act of 2019.

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

''(d) NONAPPLICATION OF CERTAIN REQUIREMENTS.—Beginning on the date described in subsection (a), any provision of this title requiring a State plan for medical assistance to make available medical assistance for services that are not institutional long-term care services or services described in section 901(a)(3)(A)(ii) of the Medicare for All Act of 2019 shall have no effect.''.

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

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

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

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

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

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

SEC. 206. STATE STANDARDS.

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

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

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

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under this Act is not a qualified provider unless the individual or entity—

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

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

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

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

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

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

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

(i) quality review by designated entities;

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

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

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

(D) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider that has had a participation agreement under this subsection terminated for cause.

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

(2) TERMINATION OF PARTICIPATION AGREEMENT.—

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

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

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Sec-

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

(C) PROVIDER PROTECTIONS.—

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

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

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

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

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

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

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

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

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of services provided under this Act and to monitor efforts by States to ensure the quality of such services. A State may also establish additional minimum standards which providers shall meet with respect to services provided in such State.

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

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction, including waiting time and access to services; and

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

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

(4) ABILITY TO PROVIDE SERVICES.—With respect to any entity or provider certified to provide services described in section 201(a)(7), the Secretary may not prohibit such entity or provider from participating for reasons other than its ability to provide such services.

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

SEC. 303. USE OF PRIVATE CONTRACTS.

(a) IN GENERAL.—Subject to the provisions of this subsection, nothing in this Act shall prohibit an institutional or individual provider from entering into a private contract with an enrolled individual for any item or service—

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

(2) for which the provider receives—

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

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

(b) BENEFICIARY PROTECTIONS.—

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

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

(B) the contract contains the items described in paragraph (2); and

(C) the contract is not entered into at a time when the beneficiary is facing an emergency health care situation.

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which subsection (a) applies shall clearly indicate to the beneficiary that by signing such contract the beneficiary—

(A) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services even if such items or services are otherwise covered by this Act;

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

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

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

(E) acknowledges that the provider is providing services outside the scope of the program under this Act.

(c) PROVIDER REQUIREMENTS.—

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

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

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

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

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

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

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

(A) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

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

(a)(2) shall be made for any such item or service).

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

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

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

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

(E) levels of funding;

(F) methods for determining amounts of payments to providers of covered services, consistent with subtitle B;

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

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

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

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

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

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

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing such services, the quality of such services, the outcomes of such services, and the equity of health among population groups. Such standards shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures, and to the maximum extent feasible without exces-

sively burdening providers, the measures described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REPORTS.—The Secretary shall regularly analyze information reported to it and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

(2) ANNUAL REPORT.—Beginning January 1 of the second year beginning after the effective date of this Act, the Secretary shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

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

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

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

(I) Differences in the health status of the populations of the different States, including income and racial characteristics, and other population health inequities.

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

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

(L) Plans for improving service to medically underserved populations.

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

(N) 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 payment or delivery as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act; and

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

(c) AUDITS.—

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

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

SEC. 402. CONSULTATION.

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

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

SEC. 403. REGIONAL ADMINISTRATION.

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

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Secretary;

(2) for each State in the region, a deputy director; and

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

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

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

(2) recommending changes in provider reimbursement or payment for delivery of health services in the States within the region; and

(3) establishing a quality assurance mechanism in the State in order to minimize both under-utilization and over-utilization and to ensure that all providers meet high-quality standards.

SEC. 404. BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of, and assistance to, individuals entitled to benefits under this Act.

(b) DUTIES.—The Beneficiary Ombudsman shall—

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

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

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

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

(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

SEC. 405. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other mat-

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

Subtitle B—Control Over Fraud and Abuse

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

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

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

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

(3) Section 1128B (criminal penalties).

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

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

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

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

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

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

(1) PRACTICE GUIDELINES.—The Center shall review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. The Center shall determine whether the guideline should be recognized as a national practice guideline.

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Center shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.). The Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by health care institutions or health care professionals. In evaluating such standards, the Center shall consider the evidentiary basis for the standard,

and the validity, reliability, and feasibility of measuring the standard.

(3) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Center shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying and notifying outliers.

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

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

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

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accurate, and timely collection of data on disparities in health care services and performance on the basis of race, ethnicity, gender, geography, or socioeconomic status. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

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

(3) Improving Universal Medicare Program data on race, ethnicity, gender, geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

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

a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status under the Universal Medicare Program; and

(B) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, gender, geography, or socioeconomic status.

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under subsection (b)(1), and 4 years thereafter, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

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

retary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, gender, geography, or socioeconomic status.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies the total expenditures to be made for covered health care services under this Act.

(2) DIVISION OF BUDGET INTO COMPONENTS.—In addition to the cost of covered health services, the national health budget shall consist of at least the following components:

(A) Quality assessment activities under title V.

(B) Health professional education expenditures.

(C) Administrative costs.

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

(E) Operating and other expenditures not described in subparagraphs (A) through (D) (referred to in this Act as the ''operating component''), consisting of amounts not included in the other components.

(F) Capital expenditures.

(G) Prevention and public health activities.

(3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the budget among the components in a manner that—

(A) ensures a fair allocation for quality assessment activities; and

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

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

become available as described in section 106(a), up to 1 percent of the budget may be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of this Act.

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

(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 equipment and includes return on equity capital.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

Subtitle B—Payments to Providers

SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL PROVIDERS.

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

(b) APPLICATION OF CURRENT AND PLANNED PAYMENT REFORMS.—Any payment reform activities or demonstrations planned or implemented with respect to such title XVIII as of the date of the enactment of this Act shall apply to benefits under this Act, including any reform activities or demonstrations planned or implemented under the provisions of, or amendments made by, the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10) and the Patient Protection and Affordable Care Act (Public Law 111–148).

SEC. 612. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

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

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

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

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

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

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

"(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.".

(c) INTERNAL TRACKING OF REVIEWS.—

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

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

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

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

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

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

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

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

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

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

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

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

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

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

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

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

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

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

''(i) IN GENERAL.—The Comptroller General of the United States (in this subparagraph referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

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

SEC. 613. OFFICE OF PRIMARY HEALTH CARE.

(a) IN GENERAL.—There is established within the Agency for Healthcare Research and Quality an Office of Primary Health Care, responsible for coordinating with the Secretary, the Health Resources and Services Administration, and other offices in the Department as necessary, in order to—

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

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

(3) develop, coordinate, and promote policies that expand the number of primary care practitioners, registered nurses, midlevel practitioners, and dentists; and

(4) recommend the appropriate training, education, technical assistance, and patient advocacy enhancements of primary care health professionals, including registered nurses, to achieve uniform high-quality and patient safety.

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

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

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

(b) PRESCRIPTION DRUG FORMULARY.—

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

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

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

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

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

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

to be known as the Universal Medicare Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits first become available as described in section 106, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by sections 801 and 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

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

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

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

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

(D) The TRICARE program, under chapter 55 of title 10, United States Code.

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

the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act.

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

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

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

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

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

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

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

"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF UNIVERSAL MEDICARE PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

''(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2019.

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

tion services furnished in a State shall reimburse the Universal Medicare Program for the cost of such services.

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

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

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

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

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the fol-

lowing: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of the Universal Medicare Program by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 521 the following new item:

''Sec 522. Prohibition of employee benefits duplicative of Universal Medicare Program benefits; coordination in case of workers' compensation.''.

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

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

(b) CONFORMING AMENDMENTS.—

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

(A) by striking paragraph (7); and

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

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

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

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

(B) by striking paragraph (8).

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

SEC. 803. EFFECTIVE DATE OF TITLE.

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

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

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

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished on or after such date;

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

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the effective date of benefits under section 106, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI such Act, the Secretary of Health and Human Serv-

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

(3) SERVICES UNDER MEDICAID.—

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

(i) institutional long-term care services (as defined in section 1947(b) of such Act); or

(ii) any other service for which benefits are not available under this Act and which is furnished under a State plan under title XIX of the Social Security Act which provided for medical assistance for such service on January 1, 2019.

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

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

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

(C) MAINTENANCE OF EFFORT REQUIREMENT.—With respect to any service described in subparagraph (A)(ii) that is made available under a State plan under title XIX of the Social Security Act, the maintenance of effort requirements described in section 1947(c) of such Act (related to eligibility standards and required expenditures) shall apply to such service in the same manner that such requirements apply to institutional long-term care services (as defined in section 1947(b) of such Act).

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring on or after the effective date.

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

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

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

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

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

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

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

TITLE X—TRANSITION

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

SEC. 1001. LOWERING THE MEDICARE AGE.

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

''TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN INDIVIDUALS

''SEC. 1899C. (a) 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 Medicare Advantage plan that provides qualified prescription drug coverage (an MA–PD plan).

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

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

''(B) The individual is—

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

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

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

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

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

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

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

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

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

''(c) PREMIUM.—

''(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with the first September following the date of enactment of the Medicare for All Act of 2019), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1/12 of the annual premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

''(2) ANNUAL PREMIUM.—

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

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

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

''(d) PAYMENT OF PREMIUMS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(2) have no negative impact on the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund).

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

ficiaries, health care providers, employers, and insurance companies.''.

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION PLAN.

(a) IN GENERAL.—To carry out the purpose of this section, for plan years beginning with the first plan year that begins after the date of enactment of this Act and ending with the effective date described in section 106, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the ''Administrator''), shall establish, and provide for the offering through the Exchanges, of a public health plan (in this Act referred to as the ''Medicare Transition plan'') that provides affordable, high-quality health benefits coverage throughout the United States.

(b) ADMINISTRATING THE MEDICARE TRANSITION.—

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

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

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

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

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

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

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

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

(d) PROVIDERS AND REIMBURSEMENT RATES.—

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

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

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

laws administered by the Secretary of Veterans Affairs;

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

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

(3) PARTICIPATING PROVIDERS.—

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

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

(e) PREMIUMS.—

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

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

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

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

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

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

(1) PREMIUM ASSISTANCE TAX CREDITS.—

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

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

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

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

All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 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 clause (ii) as clause (iii);

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

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

"(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION PLAN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019 for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

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

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

cation of clause (ii)'' after ''after application of this clause''.

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

(A) by inserting '', or in the Medicare Transition plan established under section 1002(a) of the Medicare for All Act of 2019,'' after ''coverage'' in paragraph (1);

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

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

''(1) IN GENERAL.—In this section'';

(D) by striking the flush language; and

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

''(2) SPECIAL RULES.—

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

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

''(B) MEDICARE TRANSITION PLAN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act of 2019) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition plan, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.

''(C) ADJUSTED COST-SHARING FOR MEDICARE TRANSITION PLAN ENROLLEES.—In the case of any individual who enrolls in such Medicare Transition plan, in lieu of the percentages under subsection (c)(1)(B)(i) and (c)(2), the Secretary shall prescribe a method of determining the cost-sharing reduction for any such

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

(h) CONFORMING AMENDMENTS.—

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

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

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

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

Subtitle B—Transitional Medicare Reforms

SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR FEE-FOR-SERVICE BENEFITS AND ELIMINATION OF PARTS A AND B DEDUCTIBLES.

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

''PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

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

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

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

sharing' means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

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

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

"(2) CERTAIN COSTS NOT INCLUDED.—

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

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

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

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

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

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

''(4) For each year (beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019), the inpatient hospital deductible for the year shall be $0.''.

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

(A) by striking ''and for a subsequent year'' and inserting ''for each of 2006 through the year that includes the date of enactment of the Medicare for All Act of 2019''; and

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

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

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

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

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

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

"(I) IN GENERAL.—Subject to subclause (II), for plan years beginning on or after January 1 following the date of enactment of the Medicare for All Act of 2019 and before January 1 of the year that is 4 years following such date of enactment, notwithstanding clauses (i) and (ii), the 'annual out-of-pocket threshold' speci-

fied in this subparagraph is equal to $305.

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

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

(1) in clause (i)—

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

(B) by striking ''subparagraph (B), with cost-sharing'' and inserting the following: ''subparagraph (B)—

''(I) for plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, with cost-sharing'';

(C) in item (bb), as redesignated by subparagraph (A), by striking the period at the end and inserting ''; and''; and

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

''(II) for the plan year beginning January 1 following the date of enactment of the Medicare for All Act of 2019 and the two subsequent plan years, without any cost-sharing.''; and

(2) in clause (ii)—

(A) by striking ''clause (i)(I)'' and inserting ''clause (i)(I)(aa)''; and

(B) by adding at the end the following new sentence: ''The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after plan year 2018 for purposes of 1860D–14(a)(1)(D)(iii).''.

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

(1) in paragraph (1)—

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

(B) in subparagraph (E)—

(i) in the heading, by inserting ''PRIOR TO THE ELIMINATION OF SUCH COST-SHARING FOR ALL INDIVIDUALS'' after ''THRESHOLD''; and

(ii) by striking ''The elimination'' and inserting ''For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, the elimination''; and

(2) in paragraph (2)(E)—

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

(B) by striking ''Subject to'' and inserting ''For plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2019, subject to''; and

(C) by striking ''1860D–2(b)(4)(A)(i)(I)'' and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''.

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

(a) DENTAL SERVICES.—

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

(2) COVERAGE.—

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

(i) in subparagraph (GG), by striking ''and'' at the end;

(ii) in subparagraph (HH), by striking the period at the end and inserting ''; and''; and

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

''(II) dental services;''.

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

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

(ii) by inserting before the semicolon at the end the following: ‘‘, and (DD) with respect to dental services described in section 1861(s)(2)(II), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).’’.

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

(b) VISION SERVICES.—

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

(A) in subparagraph (HH), by striking ‘‘and’’ at the end;

(B) in subparagraph (II), by inserting ‘‘and’’ at the end; and

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

‘‘(JJ) vision services;’’.

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

(A) by striking ''and'' before ''(DD)''; and

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

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

(c) HEARING AIDS AND EXAMINATIONS THEREFOR.—

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

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

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

SEC. 1014. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

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

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

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

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

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

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

(b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

SEC. 1015. GUARANTEED ISSUE OF MEDIGAP POLICIES.

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

"(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELIGIBLE MEDICARE BENEFICIARIES.—Notwithstanding paragraphs (2)(A) and (2)(D) of subsection (s) or any other provision of this section, on or after the date of enactment of this subsection, the issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of any individual entitled to, or en-

rolled for, benefits under part A and enrolled for benefits under part B.''.

Subtitle C—Private Health Insurance Availability During Transitional Period

SEC. 1021. CONTINUITY OF CARE.

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

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

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

TITLE XI—MISCELLANEOUS

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

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

(1) in subparagraph (A)—

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

(B) by inserting '', and to $6,200 on January 1, 2019'' before the period;

(2) in subparagraph (B)—

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

(B) by inserting '', and to $4,100 on January 1, 2019'' before the period; and

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

''(C) Beginning with December of 2019, whenever the dollar amounts in effect under paragraphs (1)(A) and (2)(A) of this subsection are increased for a month by a percentage under section 1617(a)(2), each of the dollar amounts in effect under this paragraph shall be increased, effective with such month, by the same percentage (and

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

SEC. 1102. DEFINITIONS.

In this Act—

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

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

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

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