

116TH CONGRESS
1ST SESSION

H. R. 2452

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 2019

Ms. DELAURO (for herself, Ms. SCHAKOWSKY, Mr. KENNEDY, Mr. CLAY, Ms. NORTON, Mr. GRIJALVA, Mr. CARBAJAL, Mrs. TRAHAN, Mr. RYAN, Ms. JACKSON LEE, Mr. THOMPSON of Mississippi, Ms. ROYBAL-ALLARD, Ms. MCCOLLUM, Ms. MOORE, Mr. RUSH, and Mr. HIGGINS of New York) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, Education and Labor, the Judiciary, Natural Resources, and House Administration, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act to establish a Medicare for America health program to provide for comprehensive health coverage for all Americans.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare for America Act of 2019”.

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

Sec. 1. Short title; table of contents.

TITLE I—TRANSITIONING TO AND ESTABLISHING MEDICARE FOR
 AMERICA

Subtitle A—Transitional Public Health Option

- Sec. 101. Establishment.
- Sec. 102. Eligibility.
- Sec. 103. Benefits.
- Sec. 104. Premiums.
- Sec. 105. Providers and reimbursement rates.
- Sec. 106. Account; funding.

Subtitle B—Medicare for America

- Sec. 111. Establishment and administration of Medicare for America.
- Sec. 112. Modifications to and coordination with existing Federal health programs.

Subtitle C—Targeted Reforms

- Sec. 121. No surprise billing.
- Sec. 122. Limitation on removal of Medicare Advantage providers by MA organizations.
- Sec. 123. Network adequacy.
- Sec. 124. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
- Sec. 125. Eliminating the waiting period for individuals on State Medicaid waiting lists.
- Sec. 126. Employer health plan options.
- Sec. 127. Prohibition on step therapy and prior authorization under group health plans.
- Sec. 128. Medicare outpatient observation services.
- Sec. 129. Abortion coverage.
- Sec. 130. Applicability of mental health parity.
- Sec. 131. Student loan forgiveness for health care providers participating in Medicare for America.
- Sec. 132. Clarification of the definition of pediatric medical necessity in qualifying group coverage.
- Sec. 133. Safe staffing requirements.
- Sec. 134. Enhancements for reduced cost-sharing.
- Sec. 135. Repeal of bonus payments for Medicare Advantage plans.

TITLE II—TAX PROVISIONS

- Sec. 201. Sunset of Public Law 115–97.
- Sec. 202. Surtax.
- Sec. 203. Basis of property acquired from a decedent.
- Sec. 204. Medicare payroll tax.
- Sec. 205. Net investment income tax.
- Sec. 206. Termination of deduction for contributions to health savings accounts.

- Sec. 207. Increase in excise tax on small cigars and cigarettes and other tobacco products.
- Sec. 208. Excise tax on alcohol.
- Sec. 209. Tax on sugared drinks.
- Sec. 210. Repeal of excise tax on high-cost employer-sponsored health coverage.

TITLE III—DRUG-RELATED PROVISIONS

- Sec. 301. Establishment of the Prescription Drug and Medical Device Review Board.
- Sec. 302. Membership; staff.
- Sec. 303. Prohibition against excessive price.
- Sec. 304. Enforcement provisions.
- Sec. 305. Authority.
- Sec. 306. Regulations.
- Sec. 307. Report to Federal agencies.
- Sec. 308. Definitions.
- Sec. 309. Moratorium on direct-to-consumer drug advertising.
- Sec. 310. Reporting on justification for drug price increases.

TITLE IV—OUTCOMES AND REPORTING

- Sec. 401. Sense of Congress.
- Sec. 402. Evaluation of bill's outcome.

1 TITLE I—TRANSITIONING TO **2 AND ESTABLISHING MEDI-** **3 CARE FOR AMERICA**

4 Subtitle A—Transitional Public **5 Health Option**

6 SEC. 101. ESTABLISHMENT.

7 The Secretary of Health and Human Services (in this
8 subtitle referred to as the “Secretary”) shall establish a
9 public health plan option that is offered in the individual
10 market through the Federal and State Exchanges under
11 title I of the Patient Protection and Affordable Care Act
12 to eligible individuals for plan years 2021 and 2022 in
13 accordance with this subtitle.

1 **SEC. 102. ELIGIBILITY.**

2 Subject to subsection (b), an individual is eligible to
3 enroll in such public health plan option if the individual
4 is otherwise eligible to purchase individual health insur-
5 ance coverage through an Exchange and the individual re-
6 sides in a rating area in which the Secretary makes the
7 public health plan option available.

8 **SEC. 103. BENEFITS.**

9 (a) IN GENERAL.—The public health plan option
10 shall be a qualified health plan within the meaning of sec-
11 tion 1301(a) of the Patient Protection and Affordable
12 Care Act (42 U.S.C. 18021(a)) that—

13 (1) meets all requirements applicable to quali-
14 fied health plans under subtitle D of title I of the
15 Patient Protection and Affordable Care Act (other
16 than the requirement under section
17 1301(a)(1)(C)(ii) of such Act (42 U.S.C.
18 18021(a)(1)(C)(ii))) and title XXVII of the Public
19 Health Service Act;

20 (2) provides coverage of the essential health
21 benefits described in section 1302(b) of the Patient
22 Protection and Affordable Care Act (42 U.S.C.
23 18022(b));

24 (3) provides silver and gold-level coverage de-
25 scribed in section 1302(d)(1)(C) of the Patient Pro-

1 tection and Affordable Care Act (42 U.S.C.
2 18022(d)(1)(C)); and

3 (4) provides coverage of comprehensive repro-
4 ductive health services, including abortion.

5 (b) PREEMPTION.—Notwithstanding section
6 1303(a)(1) of the Patient Protection and Affordable Care
7 Act (42 U.S.C. 18023(a)(1))—

8 (1) a State may not prohibit the public health
9 plan option from offering the coverage described in
10 subsection (a)(4); and

11 (2) no State law that would prohibit such a
12 plan from offering such coverage shall apply to such
13 plan.

14 **SEC. 104. PREMIUMS.**

15 (a) IN GENERAL.—The Secretary shall establish pre-
16 mium rates for the public health plan option that—

17 (1) are adjusted based on the applicable rating
18 area;

19 (2) are at a level sufficient to fully finance—

20 (A) the costs of health benefits provided by
21 such plans; and

22 (B) administrative costs related to oper-
23 ating the plans;

1 (3) comply with the requirements under section
2 2701 of the Public Health Service Act (42 U.S.C.
3 300gg); and

4 (4) ensure that no individual or household will
5 pay more than 8 percent of adjusted gross monthly
6 income toward the monthly premium.

7 (b) **FEDERAL SUBSIDIES.**—Federal subsidies shall be
8 provided to ensure that the premium shall be—

9 (1) zero in the case of an individual whose an-
10 nual household income is below 200 percent of the
11 poverty line;

12 (2) determined by a linear sliding scale, in the
13 case of an individual whose household income is at
14 least 200 percent of the poverty line, but not more
15 than 600 percent of the poverty line; and

16 (3) no individual or household above 600 per-
17 cent of poverty level will pay more than 8 percent
18 of adjusted gross monthly income toward such
19 monthly premium.

20 **SEC. 105. PROVIDERS AND REIMBURSEMENT RATES.**

21 (a) **IN GENERAL.**—The Secretary shall establish a
22 rate schedule for reimbursing types of health care pro-
23 viders furnishing items and services under the public
24 health insurance plan option at rates based on rates ap-
25 plied for such items and services under title XVIII of the

1 Social Security Act, as of the date of the enactment of
2 this Act, that are necessary to maintain network ade-
3 quacy. The Secretary shall establish a rate schedule for
4 items and services not currently covered under title XVIII
5 of the Social Security Act, such as dental, vision, and
6 hearing benefits, well child visits, and reproductive health
7 services, at a level to ensure adequate access to providers.

8 (b) PARTICIPATING PROVIDERS.—

9 (1) IN GENERAL.—A health care provider that
10 is a participating provider of services or supplier
11 under the Medicare program under title XVIII of
12 the Social Security Act or under the Medicaid pro-
13 gram under title XIX of such Act on the date of en-
14 actment of this title shall be a participating provider
15 for the public health insurance plan option.

16 (2) ADDITIONAL PROVIDERS.—The Secretary
17 shall establish a process to allow health care pro-
18 viders not described in paragraph (1) to become par-
19 ticipating providers for the public health insurance
20 plan option.

21 (3) CLARIFICATION.—Notwithstanding any
22 other provision of law, health care providers may not
23 be prohibited from participating in the public health
24 insurance option for reasons other than their ability
25 to provide covered services. Health care providers

1 and institutions are prohibited from denying covered
2 individuals access to any covered benefits and serv-
3 ices because of their religious objections.

4 (c) PRESCRIPTION DRUGS.—The Secretary shall
5 apply the provisions of section 1860D–11(i) of the Social
6 Security Act (42 U.S.C. 1395w–111(i)) to prescription
7 drugs under the public health plan option in the same
8 manner as such provisions apply with respect to applicable
9 covered part D drugs under such section.

10 **SEC. 106. ACCOUNT; FUNDING.**

11 (a) ESTABLISHMENT.—There is established in the
12 Treasury of the United States an account for the receipts
13 and disbursements attributable to the operation of the
14 public health plan option.

15 (b) APPROPRIATION.—There is appropriated to the
16 account established under subsection (a), out of any funds
17 in the Treasury not otherwise obligated, such sums as may
18 be necessary to be used by the Secretary for purposes of
19 carrying out this part.

20 (c) PROHIBITION OF STATE IMPOSITION OF
21 TAXES.—Section 1854(g) of the Social Security Act (42
22 U.S.C. 1395w–24(g)) shall apply to receipts and disburse-
23 ments described in subsection (a) in the same manner as
24 such section applies to payments or premiums described
25 in such section.

(d) CLARIFICATION.—Any provision of law restricting the use of Federal funds with respect to any reproductive health service shall not apply to funds appropriated under subsection (b) or with respect to the account under subsection (a).

Subtitle B—Medicare for America

SEC. 111. ESTABLISHMENT AND ADMINISTRATION OF MEDICARE FOR AMERICA.

The Social Security Act is amended by adding at the end the following new title:

“TITLE XXII—MEDICARE FOR AMERICA

“PART A—COMPREHENSIVE HEALTH COVERAGE

“SEC. 2201. ESTABLISHMENT.

“The Secretary shall establish a public health insurance program, to be known as ‘Medicare for America’, which shall for calendar year 2023 and each subsequent calendar year provide comprehensive health benefits in accordance with this part to individuals enrolled for coverage under this title.

“SEC. 2202. ELIGIBILITY; AUTOMATIC ENROLLMENT.

“(a) ELIGIBLE INDIVIDUALS.—For purposes of this title, every individual who is—

“(1) a resident of the United States or a territory of the United States;

1 “(2) an individual who is lawfully present, as
2 defined in section 152.2 of title 45 of the Code of
3 Federal Regulations; or

4 “(3) an individual who would be eligible for cov-
5 erage under a State Medicaid plan pursuant to sec-
6 tion 1903(v) (as such section was in effect as of the
7 date of the enactment of this title),

8 is entitled to benefits for health care services under this
9 title. The Secretary shall promulgate a rule that provides
10 criteria for applying this subsection, including determining
11 residency for eligibility purposes under this title. Nothing
12 in this title shall preclude a State from using State funds
13 to provide for an individual’s health coverage who is not
14 eligible under this subsection.

15 “(b) ENROLLMENTS.—Subject to subsection (c):

16 “(1) IN GENERAL.—Beginning in 2023, the
17 Secretary shall provide a mechanism for the enroll-
18 ment of individuals entitled to benefits under this
19 title and, in conjunction with such enrollment, the
20 issuance of a Medicare for America card which may
21 be used for purposes of identification and processing
22 of claims for benefits under this title. The card shall
23 not use the individual’s social security number as an
24 identifier. As a condition of participation in the pro-
25 gram, participating providers shall facilitate enroll-

1 ment as specified by the Secretary. The State enti-
2 ties responsible for enrolling individuals in the Med-
3 icaid program under title XIX and the Children’s
4 Health Insurance Program under title XXI shall
5 serve as the enrolling entity for Medicare for Amer-
6 ica within each State.

7 “(2) AUTOMATIC ENROLLMENTS.—The mecha-
8 nism provided under paragraph (1) shall, subject to
9 paragraph (4), provide, for plan years, for the fol-
10 lowing automatic enrollments under Medicare for
11 America:

12 “(A) ENROLLMENT AT BIRTH.—For plan
13 years (beginning with plan year 2023), a proc-
14 ess, established by the Secretary in consultation
15 with the Commissioner of Social Security, for
16 the automatic enrollment of eligible individuals
17 born during such plan year.

18 “(B) CURRENT MEDICARE BENE-
19 FICIARIES.—

20 “(i) CURRENT MEDICARE BENE-
21 FICIARIES.—For plan years (beginning
22 with plan year 2023), a process established
23 by the Secretary for the automatic enroll-
24 ment of all individuals who are enrolled for
25 benefits under part A or B of title XVIII

1 (other than individuals who are enrolled
2 for such benefits and receiving benefits
3 under title XIX).

4 “(ii) CONTINUING POPULATION.—For
5 plan years (beginning with plan year
6 2023), a process established by the Sec-
7 retary for the automatic enrollment of eli-
8 gible individuals who attain the age of 65
9 during such plan year.

10 “(iii) DUALS.—For plan years (begin-
11 ning with plan year 2025), a process estab-
12 lished by the Secretary for the automatic
13 enrollment of eligible individuals who are
14 enrolled for benefits under part A or B of
15 title XVIII and receiving benefits under
16 title XIX.

17 “(C) OTHER INDIVIDUALS WITHOUT
18 QUALIFIED HEALTH COVERAGE.—For plan
19 years (beginning with plan year 2023), a proc-
20 ess established by the Secretary for the auto-
21 matic enrollment of eligible individuals who are
22 not enrolled in other qualified health coverage
23 (as defined in paragraph (4)(B)) for such plan
24 year.

1 “(3) OTHER ENROLLMENTS.—The mechanism
2 provided under paragraph (1) shall provide for the
3 following:

4 “(A) IN GENERAL.—Enrollment periods
5 and processes for each plan year (beginning
6 with plan year 2023) for enrollment under
7 Medicare for America of any eligible individual
8 not otherwise described in paragraph (2).

9 “(B) SMALL EMPLOYERS.—

10 “(i) IN GENERAL.—For plan years
11 (beginning with plan year 2023), a process
12 and methodology under which a small em-
13 ployer, as defined in section 126(d)(3) of
14 the Medicare for America Act, may provide
15 for the enrollment of the employees of such
16 employer under Medicare for America. For
17 purposes of this subparagraph, the term
18 ‘small employer’ means any employer for
19 any calendar year if the annual payroll of
20 such employer for the preceding calendar
21 year does not exceed \$2,000,000 or has
22 fewer than 100 employees.

23 “(ii) REQUIREMENT.—Small employ-
24 ers shall either provide coverage as defined
25 within the meaning of section 2791(d)(8)

1 of the Public Health Service Act or facili-
2 tate the enrollment of their employees into
3 Medicare for America. Small employers fa-
4 cilitating enrollment into Medicare for
5 America will not be subject to a mandatory
6 employer contribution.

7 “(iii) AUTHORITY.—The Secretary
8 may set standards for determining whether
9 employers are undertaking any actions to
10 affect the risk pool within Medicare for
11 America by inducing individuals to decline
12 coverage under a qualifying employer-spon-
13 sored plan and instead to enroll in Medi-
14 care for America. An employer violating
15 such standards shall be treated as not
16 meeting the requirements of qualified
17 health coverage.

18 “(C) LARGE EMPLOYERS.—For plan years
19 (beginning with plan year 2027), the Secretary
20 shall provide for a process and methodology
21 under which a large employer may provide for
22 the enrollment of the employees of such em-
23 ployer under Medicare for America. For pur-
24 poses of the preceding sentence, the term ‘large
25 employer’ means an employer with at least 100

1 employees or whose annual payroll exceeds
2 \$2,000,000.

3 “(D) MEMBERS OF CONGRESS AND THEIR
4 STAFF.—Beginning for plan year 2023, Mem-
5 bers of Congress and their staff, subject to
6 paragraph (4), shall be enrolled in Medicare for
7 America.

8 “(4) OPT OUT FOR INDIVIDUALS ENROLLED
9 UNDER QUALIFIED HEALTH COVERAGE.—

10 “(A) IN GENERAL.—The mechanism pro-
11 vided under paragraph (1) shall provide, with
12 respect to a plan year, for a process that en-
13 ables individuals who are enrolled in qualified
14 health coverage for such plan year to opt out of
15 coverage under Medicare for America for such
16 year.

17 “(B) QUALIFIED HEALTH COVERAGE DE-
18 FINED.—For purposes of this section, the term
19 ‘qualified health coverage’ means coverage
20 under any of the following:

21 “(i) For plan years 2023 and 2024:

22 “(I) Qualified employer coverage,
23 as defined in section 126 of the Medi-
24 care for America Act.

1 “(II) Medical coverage under
2 chapter 55 of title 10, United States
3 Code, including coverage under the
4 TRICARE program.

5 “(III) A health care program
6 under chapter 17 or 18 of title 38,
7 United States Code, as determined by
8 the Secretary of Veterans Affairs, in
9 coordination with the Secretary of
10 Health and Human Services and the
11 Secretary.

12 “(IV) The health benefit program
13 under chapter 89 of title 5, United
14 States Code.

15 “(V) Medical benefits and serv-
16 ices provided by or through the Indian
17 Health Service.

18 “(VI) The Medicaid program
19 under title XIX of the Social Security
20 Act.

21 “(VII) The CHIP program under
22 title XXI of the Social Security Act.

23 “(ii) For plan years 2025 and 2026:

1 “(I) Coverage described in sub-
2 clause (I), (II), (III), (IV), or (V) of
3 clause (i).

4 “(II) Coverage described in sub-
5 clause (VI) of clause (i), but only with
6 respect to coverage that is not for in-
7 dividuals described in subclause (VIII)
8 of section 1902(a)(10)(A)(i) or who
9 are also enrolled for benefits under
10 title XVIII.

11 “(iii) For each subsequent plan year,
12 coverage described in subclause (I), (II),
13 (III), (IV), or (V) of clause (i).

14 “(c) WAIVER.—The Secretary shall establish a proc-
15 ess under which the Secretary may grant waivers to States
16 for additional time before populations described in a pre-
17 vious subsection of this section of such State are automati-
18 cally enrolled under Medicare for America so long as the
19 State can demonstrate substantial progress has been made
20 in transitioning these populations.

21 **“SEC. 2203. BENEFITS.**

22 “(a) IN GENERAL.—Medicare for America shall, in
23 accordance with this section, provide coverage for all the
24 benefits, as determined to be medically necessary, as cov-
25 ered and defined under parts A and B of title XVIII and

1 title XIX as of the date of the enactment of this title,
2 including the following:

3 “(1) Ambulatory patient services.

4 “(2) Emergency care and urgent care services.

5 “(3) Hospitalization.

6 “(4) Maternity and newborn care.

7 “(5) Behavioral health services, including men-
8 tal health, substance use disorder services, and in-
9 tensive home and community based services.

10 “(6) Prescription drugs approved by the Food
11 and Drug Administration.

12 “(7) Rehabilitative and habilitative services and
13 devices, including the following:

14 “(A) Physical therapy.

15 “(B) Speech therapy.

16 “(C) Occupational therapy.

17 “(8) Laboratory services.

18 “(9) Preventive and wellness services and
19 chronic disease management.

20 “(10) Pediatric services, all services that would
21 otherwise be coverable under early and periodic
22 screening, diagnostic, and treatment under the Med-
23 icaid program under title XIX and services otherwise
24 included under the maternal, infant, and early child-

1 hood home visiting program under section 511, as of
2 the date of the enactment of this title.

3 “(11) Dental care, at a minimum the services
4 necessary to prevent disease and promote oral
5 health, restore oral structures to health and func-
6 tion, and treat emergency conditions, nightguards,
7 mouthguards, and dentures.

8 “(12) Hearing health services including aids
9 and exams.

10 “(13) Vision services.

11 “(14) Home and community based long-term
12 services and supports.

13 “(15) Chiropractic services.

14 “(16) Durable medical equipment (as defined
15 for purposes of title XIX), including the following:

16 “(A) Wheelchairs and accessories.

17 “(B) Walking aides such as walkers, canes,
18 and crutches.

19 “(C) Bathroom equipment such as com-
20 modes and safety equipment.

21 “(D) Inhalation therapy equipment such as
22 nebulizers.

23 “(E) Hospital beds and accessories.

1 “(F) Other devices such as Continuous
2 Positive Airway Pressure (CPAP) machines,
3 apnea monitors, and ventilators.

4 “(G) Insulin pumps and glucometers.

5 “(H) Breast pumps.

6 “(I) Lymphedema compression treatment
7 items.

8 “(J) Wigs for medical conditions.

9 “(K) Augmentative and alternative com-
10 munication devices, including dual-use devices.

11 “(L) Oxygen.

12 “(M) Orthotic and prosthetic devices.

13 “(N) Disposable medical supplies.

14 “(17) Family planning, including the following:

15 “(A) Reproductive health exams.

16 “(B) Patient counseling and education re-
17 lated to family planning.

18 “(C) Abortion.

19 “(D) Screening, testing, treatment, and
20 pre- and post-test counseling for sexually trans-
21 mitted diseases and HIV.

22 “(E) Contraceptives including pill, patch,
23 medication, condom, implant, or other devices
24 used to prevent pregnancy.

1 “(F) Voluntary sterilization for bene-
2 ficiaries over the age of 21.

3 “(G) Infertility treatment.

4 “(18) Gender-confirming medical procedures
5 and treatment.

6 “(19) Screening, testing, treatment, and pre-
7 and post-test counseling for sexually transmitted dis-
8 eases and HIV.

9 “(20) Dietary and nutrition counseling.

10 “(21) Medically necessary food and vitamins for
11 digestive and inherited metabolic disorders.

12 “(22) Nursing facilities.

13 “(23) Acupuncture.

14 “(24) Digital health therapeutics, as approved
15 by the Center for Healthcare and the Center for
16 Medicare and Medicaid Innovation.

17 “(25) Telehealth.

18 “(26) Non-emergency medical transportation.

19 “(27) Care coordination, including services de-
20 fined in section 440.169 of title 42, Code of Federal
21 Regulations.

22 “(28) Palliative care.

23 “(29) Any additional benefit or service not in-
24 cluded in this section that is coverable by any State

1 plan (or waiver of such State plan) under title XIX
2 on the date of the enactment of this title.

3 “(b) UPDATES.—Benefits coverable under Medicare
4 for America shall be updated in accordance with the Na-
5 tional Coverage Determination process that had, as of the
6 date before the date of the enactment of this title, applied
7 with respect to benefits covered under title XVIII.

8 “(c) IMPLEMENTING POLICIES.—The Secretary shall
9 establish payment models, quality measures, and other im-
10 plementing policies that provide further access to the cov-
11 erage under this title. For purposes of the previous sen-
12 tence, the Secretary shall consult with stakeholders, in-
13 cluding those covering pediatrics, disabilities, and seniors.

14 “(d) PROHIBITION AGAINST DUPLICATING COV-
15 ERAGE.—

16 “(1) IN GENERAL.—It is unlawful for a private
17 health insurer (other than an insurer with respect to
18 a Medicare Advantage for America plan under part
19 C of this title or qualified employer-based coverage)
20 to sell health insurance coverage that duplicates the
21 benefits provided under Medicare for America under
22 this part.

23 “(2) CONSTRUCTION.—Nothing in paragraph
24 (1) shall be construed as prohibiting the sale of
25 health insurance coverage for any additional benefits

1 not covered by this part, insofar as the coverage sat-
2 isfies the conditions of paragraphs (3) and (4).
3 Nothing shall preclude employers meeting the re-
4 quirements under section 126 of the Medicare for
5 America Act from providing supplemental coverage
6 under this section to their employees.

7 “(3) APPLICATION OF PROTECTIONS.—For pur-
8 poses of paragraph (2), health insurance coverage
9 for any additional benefits must satisfy the following
10 conditions:

11 “(A) The provisions of section 2718 of the
12 Public Health Service Act, relating to a medical
13 loss ratio.

14 “(B) The provisions of section 2702 of the
15 Public Health Service Act, relating to guaran-
16 teed issue.

17 “(C) The provisions of section 2701 of the
18 Public Health Service Act, relating to commu-
19 nity rating.

20 “(D) The provisions of section 2704 of the
21 Public Health Service Act, relating to the ban
22 on pre-existing conditions exclusions.

23 “(4) NO FEES TO BROKERS.—For purposes of
24 paragraph (2), the condition described in this para-
25 graph is that health insurance coverage described in

1 such paragraph does not pay fees to insurance bro-
2 kers.

3 “(e) STATES MAY PROVIDE ADDITIONAL BENE-
4 FITS.—Individual States may provide additional benefits
5 for the residents of such States at the expense of the
6 State.

7 “(f) PROHIBITION AGAINST STEP THERAPY AND
8 PRIOR AUTHORIZATION.—Items and services covered
9 under Medicare for America shall be covered without any
10 need for any prior authorization determination and with-
11 out any limitation applied through the use of step therapy
12 protocols.

13 **“SEC. 2204. PREMIUMS.**

14 “(a) IN GENERAL.—

15 “(1) IN GENERAL.—Subject to paragraph (2),
16 each individual enrolled for benefits under this title
17 for a year shall pay monthly community-rated pre-
18 miums for such year in an amount determined by
19 the Secretary in accordance with subsection (b).

20 “(2) GRANDFATHERED MEDICARE BENE-
21 FICIARIES.—In the case of an individual enrolled
22 under part B of title XVIII as of the date of the en-
23 actment of this part, the premium applied under this
24 section for such individual for benefits under this
25 title shall be the lesser of—

1 “(A) the premium otherwise applicable to
2 such individual under such title XVIII if this
3 title had not been enacted; or

4 “(B) the premium that would be applied to
5 such individual under this title without the ap-
6 plication of this paragraph.

7 “(b) PREMIUM CONTRIBUTION BASED ON INCOME.—
8 The amount of a monthly premium, with respect to a plan
9 year (beginning with 2023), under this section shall be
10 established by the Secretary in accordance with the fol-
11 lowing:

12 “(1) Such premium shall be determined such
13 that the collective premiums for the plan year are
14 with respect to the costs of health benefits provided
15 under this title for such year and related administra-
16 tive costs.

17 “(2) Premiums shall vary by family composition
18 only.

19 “(3) Federal subsidies shall be provided to en-
20 sure that the premium shall be—

21 “(A) zero in the case of an individual
22 whose annual household income is below 200
23 percent of the poverty line;

24 “(B) determined by a linear sliding scale,
25 in the case of an individual whose household in-

1 come is at least 200 percent of the poverty line,
2 but not more than 600 percent of the poverty
3 line; and

4 “(C) no individual or household will pay
5 more than 8 percent of adjusted gross monthly
6 income toward such premium.

7 “(4) For an individual whose employer will be
8 making a firm-wide contribution under this title in
9 lieu of offering employer-sponsored insurance (as
10 specified in section 126(b)(1)(B) of the Medicare for
11 America Act), such individual shall pay a premium
12 in accordance with this subsection.

13 “(5) For an individual who has opted out of
14 their employer-sponsored insurance in order to enroll
15 in Medicare for America as specified in section
16 126(c) of such Act, the individual shall pay the less-
17 er of—

18 “(A) the premium described in this sub-
19 section; or

20 “(B) the amount owed after the amount of
21 employer contribution (as specified in section
22 126(b)(1)(B) of the Medicare for America Act)
23 is subtracted from the premium established by
24 the Secretary of Health and Human Services as
25 described in paragraph (1), whichever is less.

1 “(c) DEPOSITS.—Amounts paid under this section for
2 coverage under this title shall be deposited in the Treasury
3 to the credit of the Trust Fund established under section
4 2206.

5 “(d) APPEALS FOR CERTAIN MEDICARE GRAND-
6 FATHERED POPULATION.—In calculating premiums for
7 purposes of subsection (a)(2):

8 “(1) Any individual that was subject to a late
9 enrollment penalty under part B of title XVIII shall
10 have the right to appeal the assessment of the pen-
11 alty for good faith enrollment mistakes.

12 “(2) The Secretary, in consultation with the
13 Commissioner of Social Security, shall develop and
14 publish a formal application for requesting an action
15 of the Secretary under paragraph (1) to correct or
16 eliminate the effects of an error, misrepresentation,
17 or inaction described in such paragraph and deter-
18 mine and publish specific timelines for timely resolu-
19 tion of such a request.

20 “(3) The Secretary shall also require that all
21 such determinations with respect to such requests
22 shall be reached within 15 business days of the sub-
23 mission of such application. All determinations shall
24 be in writing through a standard decision notice

1 which shall include an explanation of the reasons for
2 the determination.

3 “(4) The Commissioner of Social Security shall
4 enter into contracts with independent review organi-
5 zations in accordance with this subsection for the
6 purpose of reviewing and determining individual ap-
7 peals of determinations under paragraph (3) with re-
8 spect to an application relating to enrollment under
9 part A or part B.

10 “(5) An individual who receives an adverse de-
11 termination under paragraph (3) may appeal to an
12 independent review organization designated by the
13 Commission. Any such appeal must be sent to the
14 independent review organization within 90 days of
15 the date the individual received the determination to
16 be eligible for review. The independent review orga-
17 nization shall review and reach a determination of
18 the review in writing within 45 days of the receipt
19 of any such appeal.

20 “(6) The Secretary of the Treasury may not
21 enter into a contract under paragraph (4) with an
22 independent review organization—

23 “(A) unless the organization has staff that
24 has the appropriate knowledge of, and experi-
25 ence with, the eligibility and coordination of

1 benefits rules and regulations under this title;
2 and

3 “(B) to the extent the organization is a fis-
4 cal intermediary under section 1816, a carrier
5 under section 1842, or a Medicare administra-
6 tive contractor under section 1874A.

7 “(7) The Secretary shall provide for access by
8 independent review organizations conducting appeal
9 determinations under this subsection, to the data-
10 base of the Coordination of Benefits Contractor of
11 the Centers for Medicare & Medicaid Services as
12 necessary in order to conduct the duties of such or-
13 ganizations to determine appeals pursuant to this
14 subsection.

15 **“SEC. 2205. PAYMENT OF BENEFITS; COST-SHARING; OUT-**
16 **OF-POCKET LIMITS.**

17 “(a) PAYMENT OF BENEFITS; COST-SHARING.—
18 There shall be paid, in the case of each individual who
19 is enrolled under Medicare for America and incurs ex-
20 penses for items and services with respect to which bene-
21 fits are payable under this part, subject to subsection (c),
22 80 percent of the reimbursement rates established pursu-
23 ant to section 2206 for such items and services, except
24 that for the following services, the amounts paid under
25 this section shall be equal to 100 percent of the reimburse-

1 ment rates established pursuant to section 2206 for such
2 items and services:

3 “(1) USPTF recommended preventive and
4 chronic disease services.

5 “(2) Long-term services and supports.

6 “(3) Generic drugs, and prescription drugs if
7 medically necessary.

8 “(4) All services for individuals who are medi-
9 cally frail or otherwise have special medical needs,
10 (including children with serious emotional disturb-
11 ance and adults with serious mental illness), individ-
12 uals with chronic substance use disorders, or individ-
13 uals with serious and complex medical conditions
14 (such as epilepsy and HIV), individuals with a phys-
15 ical, intellectual or developmental disability that sig-
16 nificantly impairs their ability to perform one or
17 more activities of daily living.

18 “(5) Pregnancy related services.

19 “(6) Emergency services.

20 “(7) Services for children under age 21.

21 The Secretary shall establish a default monthly payment
22 plan under the Medicare for America benefits package to
23 ensure the payment owed by the individual enrolled under
24 Medicare for America is spread-out evenly throughout the
25 year.

1 “(b) DEDUCTIBLE.—There shall be no deductible
2 under Medicare for America.

3 “(c) MAXIMUM OUT-OF-POCKET LIMIT.—

4 “(1) IN GENERAL.—The coverage under Medi-
5 care shall provide benefits, after the eligible indi-
6 vidual has incurred out-of-pocket expenses for items
7 and services with respect to which benefits are pay-
8 able under this part in a year equal to the annual
9 out-of-pocket threshold specified in paragraph (2),
10 with cost-sharing that is equal to \$0.

11 “(2) ANNUAL OUT-OF-POCKET THRESHOLD.—

12 “(A) IN GENERAL.—For purposes of para-
13 graph (1), subject to subparagraphs (B) and
14 (C), the annual out-of-pocket threshold speci-
15 fied in this paragraph is a threshold that shall
16 be determined on a linear sliding scale for
17 household income that is at least 200 percent of
18 the poverty line, but not more than 600 percent
19 of the poverty line, and that shall not exceed—

20 “(i) with respect to an individual,
21 \$3,500; or

22 “(ii) with respect to a household,
23 \$5,000.

24 Individuals or households with income above
25 600 percent of the Federal poverty line shall

1 have their annual out-of-pocket threshold
2 capped at \$3,500 and \$5,000 respectively.

3 “(B) INDEXING.—In the case of plan years
4 beginning after 2021, the threshold described in
5 subparagraph (A) (as in effect for the preceding
6 plan year after application of this subpara-
7 graph) shall be increased by the percentage in-
8 crease over the previous year in the medical
9 care expenditure category of the Consumer
10 Price Index for All Urban Consumers (United
11 States city average), published by the Bureau
12 of Labor Statistics.

13 “(C) EXCEPTION.—For purposes of para-
14 graph (1), the annual out-of-pocket threshold
15 for individuals and households with annual in-
16 come below 200 percent of the Federal poverty
17 line is \$0.

18 “(d) NO LIFETIME OR ANNUAL LIMITS.—There shall
19 be no lifetime or annual limits for any services or benefits
20 coverable under Medicare for America.

21 “(e) NO BALANCE BILLING.—No provider may im-
22 pose a charge to an enrolled individual for coverable serv-
23 ices for which benefits are provided under this part in an
24 amount higher than the reimbursement rate for such serv-
25 ices under section 2206 and may not impose a charge to

1 such individual for such service other than with respect
 2 to the other cost-sharing described in this section.

3 “(f) NO PRIVATE CONTRACTING.—A health care pro-
 4 vider or health care institution are prohibited from enter-
 5 ing into a private contract with an individual enrolled
 6 under Medicare for America for any item or service
 7 coverable under Medicare for America.

8 “(g) LIMITATIONS ON THE USE OF FLEXIBLE SAV-
 9 INGS ACCOUNTS.—Flexible Savings Accounts shall only be
 10 used for benefits and services not covered by Medicare for
 11 America.

12 **“SEC. 2206. PROVIDERS NETWORK AND REIMBURSEMENT**
 13 **RATES.**

14 “(a) IN GENERAL.—The Secretary shall establish a
 15 rate schedule for reimbursing types of health care pro-
 16 viders furnishing items and services under Medicare for
 17 America at rates that are consistent with subsection (b)
 18 and are necessary to maintain network adequacy.

19 “(b) RATES.—

20 “(1) IN GENERAL.—Except as provided in para-
 21 graphs (2) and (3), the Secretary shall establish
 22 rates for benefits and services to be provided to
 23 health care providers and suppliers furnishing under
 24 Medicare for America based on rates that would be
 25 applied (including as computed, updated, and ad-

1 justed) under title XVIII or title XIX, whichever is
2 higher, for such type of health care providers and
3 suppliers and item and service if such title remained
4 in effect and, in the case of a type of provider and
5 supplier or item or service coverable under Medicare
6 for America but not otherwise coverable under title
7 XVIII or title XIX, shall provide for rates that en-
8 sure adequate access to care.

9 “(2) EXCEPTIONS.—For purposes of this sec-
10 tion, in applying paragraph (1) the Secretary shall
11 ensure that rates to hospitals for inpatient services
12 or outpatient services furnished under Medicare for
13 America are at least 110 percent of such rates on
14 average or in the aggregate for furnishing such inpa-
15 tient or outpatient services otherwise applied under
16 title XVIII or title XIX, whichever is higher, except
17 that for hospitals serving underserved areas as speci-
18 fied by the Secretary, such rates are increased as
19 necessary to ensure adequate access to care.

20 “(3) APPLICATION.—In applying rates under
21 title XVIII and title XIX, as applicable, for purposes
22 of this part, the following shall apply:

23 “(A) The Secretary shall provide for site-
24 neutral payments for items and services fur-
25 nished in an outpatient hospital and physician

1 office, the rate of payment for such service shall
2 be the same.

3 “(B) The Secretary shall provide for a
4 mechanism to provide payments for direct and
5 indirect costs of graduate medical education
6 programs without any cap on the number of
7 residency positions for which payment may be
8 made, including payments to hospitals for such
9 programs and to eligible facilities for programs
10 for population health-based residencies and for
11 nurse practitioner post-licensure clinical train-
12 ing, residency, and fellowship programs.

13 “(C) The Secretary shall increase the aver-
14 age relative value of primary care and other
15 mental and behavioral health and cognitive
16 services by not less than 30 percent in order to
17 ensure adequate access to inpatient and out-
18 patient care.

19 “(D) As a condition of participation in the
20 program, participating providers shall accept
21 Medicare for America rates paid by employer-
22 sponsored insurance plans and Medicare Advan-
23 tage for America plans.

24 “(E) The Secretary shall semiannually re-
25 view if the rates paid by Medicare for America

1 are creating barriers to care. The Secretary
2 shall have the authority to raise rates as nec-
3 essary to ensure adequate access to care.

4 “(4) INCREASED FEDERAL MATCH FOR MED-
5 ICAID AND THE CHILDREN’S HEALTH INSURANCE
6 PROGRAM FOR YEARS 2023 THROUGH 2027.—The
7 Secretary of Health and Human Services shall pay
8 the difference between the Medicare for America
9 rates and the Medicaid and CHIP rates during the
10 period beginning on January 1, 2023, and ending on
11 December 31, 2027.

12 “(c) PARTICIPATING PROVIDERS.—

13 “(1) IN GENERAL.—A health care provider that
14 is a participating provider of services or supplier
15 under the Medicare program under title XVIII or
16 the Medicaid program under title XIX on the date
17 of enactment of this title shall remain a partici-
18 pating provider for Medicare for America.

19 “(2) ADDITIONAL PROVIDERS.—The Secretary
20 shall establish a process to allow health care pro-
21 viders not described in paragraph (1) to become par-
22 ticipating providers for Medicare for America.

23 “(d) PRESCRIPTION DRUGS.—

24 “(1) IN GENERAL.—Notwithstanding any other
25 provision of law, the Secretary shall, for plan years

1 beginning on or after the date of the enactment of
2 this title, negotiate with pharmaceutical manufactur-
3 ers the prices (including discounts, rebates, and
4 other price concessions) that may be charged to
5 Medicare for America and MA for America organiza-
6 tions during a negotiated price period (as specified
7 by the Secretary) for covered drugs for Medicare for
8 America enrollees. In negotiating such prices under
9 this section, the Secretary shall take into account
10 the following factors:

11 “(A) The comparative clinical effectiveness
12 and cost effectiveness, when available from an
13 impartial source, of such drug.

14 “(B) The budgetary impact of providing
15 coverage of such drug.

16 “(C) The number of similarly effective
17 drugs or alternative treatment regimens for
18 each approved use of such drug.

19 “(D) The associated financial burden on
20 patients that utilize such drug.

21 “(E) The associated unmet patient need
22 for such drug.

23 “(F) The total revenues from global sales
24 obtained by the manufacturer for such drug

1 and the associated investment in research and
2 development of such drug by the manufacturer.

3 “(2) FINALIZATION OF NEGOTIATED PRICE.—

4 The negotiated price of each covered drug for a ne-
5 gotiated price period shall be finalized not later than
6 30 days before the first plan year in such negotiated
7 price period.

8 “(3) COMPETITIVE LICENSING AUTHORITY.—

9 “(A) IN GENERAL.—Notwithstanding any
10 exclusivity under clause (iii) or (iv) of section
11 505(j)(5)(F) of the Federal Food, Drug, and
12 Cosmetic Act, clause (iii) or (iv) of section
13 505(c)(3)(E) of such Act, section 351(k)(7)(A)
14 of the Public Health Service Act, or section
15 527(a) of the Federal Food, Drug, and Cos-
16 metic Act, or by an extension of such exclusivity
17 under section 505A of such Act or section 505E
18 of such Act, and any other provision of law that
19 provides for market exclusivity (or extension of
20 market exclusivity) with respect to a drug, in
21 the case that the Secretary is unable to success-
22 fully negotiate an appropriate price for a cov-
23 ered drug for a negotiated price period, the Sec-
24 retary shall authorize the use of any patent,
25 clinical trial data, or other exclusivity granted

1 by the Federal Government with respect to such
2 drug as the Secretary determines appropriate
3 for purposes of manufacturing such drug for
4 sale under Medicare for America. Any entity
5 making use of a competitive license to use pat-
6 ent, clinical trial data, or other exclusivity
7 under this section shall provide to the manufac-
8 turer holding such exclusivity reasonable com-
9 pensation, as determined by the Secretary
10 based on the following factors:

11 “(i) The risk-adjusted value of any
12 Federal Government subsidies and invest-
13 ments in research and development used to
14 support the development of such drug.

15 “(ii) The risk-adjusted value of any
16 investment made by such manufacturer in
17 the research and development of such
18 drug.

19 “(iii) The impact of the price, includ-
20 ing license compensation payments, on
21 meeting the medical need of all patients.

22 “(iv) The relationship between the
23 price of such drug, including compensation
24 payments, and the health benefits of such
25 drug.

1 “(v) Other relevant factors determined
2 appropriate by the Secretary to provide
3 reasonable compensation.

4 “(B) REASONABLE COMPENSATION.—The
5 manufacturer described in subparagraph (A)
6 may seek recovery against the United States in
7 the United States Court of Federal Claims.

8 “(C) INTERIM PERIOD.—

9 “(i) IN GENERAL.—Until 1 year after
10 a drug described in subparagraph (A) is
11 approved under section 505(j) of the Fed-
12 eral Food, Drug, and Cosmetic Act or sec-
13 tion 351(k) of the Public Health Service
14 Act and is provided under license issued by
15 the Secretary under such subparagraph,
16 Medicare for America shall not pay more
17 for such drug than the average of the
18 prices available, during the most recent 12-
19 month period for which data is available
20 prior to the beginning of such negotiated
21 price period, from the manufacturer to any
22 wholesaler, retailer, provider, health main-
23 tenance organization, nonprofit entity, or
24 governmental entity in the ten OECD (Or-
25 ganization for Economic Cooperation and

1 Development) countries that have the larg-
2 est gross domestic product with a per cap-
3 ita income that is not less than half the
4 per capita income of the United States or
5 the price established by the Prescription
6 Drug and Medical Device Review Board
7 established under title III of the Medicare
8 for America Act of 2019.

9 “(ii) FEDERAL PROGRAM LICENS-
10 ING.—If such drug is not made available
11 at the price determined, the Secretary shall
12 authorize such entities to use any patent,
13 clinical trial data, or other exclusivity
14 granted by the Federal Government with
15 respect to such drug as the Secretary de-
16 termines appropriate for purposes of man-
17 ufacturing such drug for sale under any
18 Federal program, including those provided
19 by Medicare for America, Veterans Affairs,
20 the Department of Defense, and the Coast
21 Guard.

22 “(D) AUTHORIZATION FOR SECRETARY TO
23 PROCURE DRUGS DIRECTLY.—

24 “(i) IN GENERAL.—The Secretary
25 may procure a drug manufactured pursu-

1 ant to a competitive license under subpara-
2 graph (A) for purposes of this part or pur-
3 suant to a Federal program license under
4 subparagraph (C)(ii) for purposes of a
5 Federal program directly from the entity
6 manufacturing the drug pursuant to such
7 a license.

8 “(ii) CLARIFICATION REGARDING AP-
9 PPLICATION OF BUY AMERICAN ACT.—In
10 the case where the Secretary procures a
11 drug under this subparagraph, the provi-
12 sions of chapter 83 of title 41, United
13 States Code (commonly referred to as the
14 ‘Buy American Act’), shall apply.

15 “(E) PRIORITY FOR U.S. MANUFACTURERS
16 IN AUTHORIZING COMPETITIVE LICENSES.—In
17 authorizing a competitive license under this
18 paragraph, the Secretary—

19 “(i) shall give preference to entities
20 that the Secretary determines have the
21 highest safety and security standards; and

22 “(ii) may give priority to entities that
23 will manufacture such drug in the United
24 States.

1 “(4) FDA REVIEW OF LICENSED DRUG APPLI-
2 CATIONS.—The Secretary shall prioritize review of
3 applications under section 505(j) of the Federal
4 Food, Drug, and Cosmetic Act for drugs licensed
5 under paragraph (3)(A).

6 “(5) PROHIBITION OF ANTICOMPETITIVE BE-
7 HAVIOR.—No drug manufacturer may engage in
8 anticompetitive behavior with another manufacturer
9 that may interfere with the issuance and implemen-
10 tation of a competitive license or run contrary to
11 public policy.

12 “(6) REQUIRED REPORTING.—The Secretary
13 may require pharmaceutical manufacturers to dis-
14 close to the Secretary such information that the Sec-
15 retary determines necessary for purposes of carrying
16 out this subsection.

17 “(7) CLARIFICATION.—Nothing in this sub-
18 section shall be construed as preventing Medicare for
19 America obtaining a discount or reduction of the
20 price for a covered drug below the price negotiated
21 by the Secretary.

22 “(8) VALUE OR COST-EFFECTIVENESS ASSESS-
23 MENTS.—The use of Quality-Adjusted Life Years,
24 Disability-Adjusted Life Years, or other similar
25 mechanisms is prohibited for use in value or cost-ef-

1 fectiveness assessments for purposes of this sub-
2 section.

3 “(9) CLARIFICATION.—There shall be no for-
4 mulary under Medicare for America.

5 **“SEC. 2207. TRUST FUND; FUNDING.**

6 “(a) TRUST FUND.—There shall be established a uni-
7 fied Medicare Trust Fund in which funds provided under
8 this title are deposited and from which expenditures under
9 this title are made. The Trust Fund shall consist of such
10 gifts and bequests as may be made and such amounts as
11 may be deposited in, or appropriated to, such Trust Fund
12 as provided in this Act.

13 “(b) FUNDING.—

14 “(1) TAXES.—There are hereby appropriated to
15 the Trust Fund for each fiscal year beginning with
16 fiscal year 2023, out of any moneys in the Treasury
17 not otherwise appropriated, amounts equivalent to
18 100 percent of the net increase in revenues to the
19 Treasury which is attributable to the amendments
20 made by title II of the Medicare for America Act
21 and premiums collected under this title. The
22 amounts appropriated by the preceding sentence
23 shall be transferred from time to time (but not less
24 frequently than monthly) from the general fund in
25 the Treasury to the Trust Fund, such amounts to be

1 determined on the basis of estimates by the Sec-
2 retary of the Treasury of the taxes paid to or depos-
3 ited into the Treasury; and proper adjustments shall
4 be made in amounts subsequently transferred to the
5 extent prior estimates were in excess of or were less
6 than the amounts that should have been so trans-
7 ferred.

8 “(2) CURRENT PROGRAM RECEIPTS.—Notwith-
9 standing any other provision of law, there are hereby
10 appropriated to the Trust Fund for each fiscal year,
11 beginning with fiscal year 2023, the amounts that
12 would otherwise have been appropriated to carry out
13 the following programs:

14 “(A) The Medicare program under title
15 XVIII.

16 “(B) The Medicaid program under title
17 XIX, beginning as of 2027.

18 “(3) ADDITIONAL APPROPRIATIONS.—Addi-
19 tional sums are authorized to be appropriated annu-
20 ally as needed to maintain maximum quality, effi-
21 ciency, and access under this part.

22 “(4) MEDICAID MAINTENANCE OF EFFORT PAY-
23 MENTS.—There shall be transferred to the Trust
24 Fund the maintenance of effort payments made
25 under section 2209.

1 “(c) RESTRICTIONS SHALL NOT APPLY.—Any other
2 provision of law in effect on the date of enactment of this
3 title restricting the use of Federal funds for any reproduc-
4 tive health service, including abortion, shall not apply to
5 monies in the Trust Fund.

6 “(d) INCORPORATION OF PROVISIONS.—The provi-
7 sions of subsections (b) through (i) of section 1817 shall
8 apply to the Trust Fund under this section in the same
9 manner as such provisions applied to the Federal Hospital
10 Insurance Trust Fund under such section 1817, except
11 that, for purposes of applying such subsections to this sec-
12 tion, the ‘Board of Trustees of the Trust Fund’ shall mean
13 the ‘Secretary’.

14 “(e) TRANSFER OF FUNDS.—Any amounts remain-
15 ing in the Federal Hospital Insurance Trust Fund under
16 section 1817 or the Federal Supplementary Medical Insur-
17 ance Trust Fund under section 1841 after the payment
18 of claims for items and services furnished under title
19 XVIII have been completed, shall be transferred into the
20 Trust Fund under this section.

21 **“SEC. 2208. ADMINISTRATIVE PROVISIONS.**

22 “(a) CENTER FOR HEALTH CARE.—Beginning 2023,
23 the Centers for Medicare & Medicaid Services shall be re-
24 named the Center for Health Care and all references in
25 law and regulation to such Centers shall be deemed a ref-

1 erence to such Center. All powers, duties, and responsibil-
 2 ities of the Centers for Medicare & Medicaid Services shall
 3 be transferred to the Center for Health Care.

4 “(b) AUTHORITY.—The Secretary shall have the au-
 5 thority to issue interim final rules with respect to any pro-
 6 vision in this part.

7 “(c) ADMINISTRATIVE LAW JUDGES.—

8 “(1) IN GENERAL.—The Center for Health
 9 Care is not authorized to appoint administrative law
 10 judges, in accordance with pages 11420 through
 11 11499 of title 70 of the Federal Register (March 8,
 12 2005).

13 “(2) TIMING.—Under this title, administrative
 14 law judges must issue a decision within 90 days of
 15 receipt of a hearing request, as specified in sub-
 16 sections (a) and (c) of section 405.1016 of title 2,
 17 Code of Federal Regulations.

18 “(d) COVERAGE DETERMINATIONS APPEALS.—

19 “(1) Individuals may appeal a coverage deter-
 20 mination under this title before the individual ob-
 21 tains the service or item that is the subject of the
 22 appeal. Individuals shall continue to receive the serv-
 23 ice or item if an appeal is filed before the provision
 24 of the service or item is terminated.

1 “(2) The Secretary shall eliminate the redeter-
2 mination by a Medicare administrative contractor
3 from the appeals process under the Medicare pro-
4 gram for beneficiaries.

5 “(e) PRIVATE RIGHT OF ACTION.—

6 “(1) IN GENERAL.—An applicant or recipient
7 denied a right conferred by this title may bring a
8 civil action seeking any remedy available in law or
9 equity to remedy that violation. State courts and
10 district courts of the United States shall have con-
11 current jurisdiction of such actions.

12 “(2) RIGHT DEFINED.—Rights are created by
13 any provision of this title that—

14 “(A) prescribes, establishes, or confers a
15 benefit or protection in favor of the individual
16 or individuals seeking to enforce the provision;
17 or

18 “(B) prescribes, establishes, or imposes a
19 duty or obligation on a person or entity to act
20 or conduct operations in a manner that benefits
21 the individual or individuals seeking to enforce
22 the provision.

23 “(3) REASONABLE ATTORNEY FEES.—In any
24 action or proceeding to enforce this title, the court
25 may award reasonable attorneys’ fees and litigation

1 costs (including expert fees) reasonably incurred
2 against the defendant or defendants.

3 “(4) APPEAL.—Any civil action brought under
4 this section shall be subject to appeal as provided in
5 sections 1291 and 1292 of title 28 of the United
6 States Code.

7 “(5) CONTINUED APPLICATION OF OTHER
8 LAWS.—Nothing in this title (or an amendment
9 made by this title) shall be construed to invalidate
10 or limit the rights, remedies, procedures, or legal
11 standards available to individuals aggrieved under
12 section 1979 of the Revised Statutes (42 U.S.C.
13 1983), or to supersede State laws causes of action.

14 “(f) NON-DISCRIMINATION.—

15 “(1) IN GENERAL.—Except as otherwise pro-
16 vided for in this title, an individual shall not, on the
17 ground prohibited under title VI of the Civil Rights
18 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of
19 the Education Amendments of 1972 (20 U.S.C.
20 1681 et seq.), the Age Discrimination Act of 1975
21 (42 U.S.C. 6101 et seq.), section 504 of the Reha-
22 bilitation Act of 1973 (29 U.S.C. 794), or section
23 1557 of the Affordable Care Act (42 U.S.C. 18116),
24 be excluded from participation in, be denied the ben-
25 efits of, or be subjected to discrimination under, any

1 health program or activity, any part of which is re-
2 ceiving Federal financial assistance, including cred-
3 its, subsidies, or contracts of insurance, or under
4 any program or activity that is administered by an
5 Executive Agency or any entity established under
6 this title (or amendments) or any employer-spon-
7 sored insurance. The enforcement mechanisms pro-
8 vided for and available under such title VI, title IX,
9 section 794, Age Discrimination Act, or such section
10 1557 shall apply for purposes of violations of this
11 subsection.

12 “(2) CONTINUED APPLICATION OF LAWS.—
13 Nothing in this title (or an amendment made by this
14 title) shall be construed to invalidate or limit the
15 rights, remedies, procedures, or legal standards
16 available to individuals aggrieved under title VI of
17 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
18 seq.), title VII of the Civil Rights Act of 1964 (42
19 U.S.C. 2000e et seq.), title IX of the Education
20 Amendments of 1972 (20 U.S.C. 1681 et seq.), sec-
21 tion 504 of the Rehabilitation Act of 1973 (29
22 U.S.C. 794), the Age Discrimination Act of 1975
23 (42 U.S.C. 611 et seq.), or section 1557 of the Af-
24 fordable Care Act (42 U.S.C. 18116) or to super-
25 sede State laws that provide additional protections

1 against discrimination on any basis described in
2 paragraph (1).

3 “(3) HEALTH CARE PROVIDERS.—Health care
4 providers may not be prohibited from participating
5 in the Medicare for America for reasons other than
6 their ability to provide covered services. Health care
7 providers and institutions are prohibited from deny-
8 ing covered individuals access to covered benefits
9 and services because of their religious objections.
10 This subsection supercedes any provision of law that
11 allows for conscience protection.

12 “(4) REGULATIONS.—The Secretary may pro-
13 mulgate regulations to implement this subsection.

14 **“SEC. 2209. MAINTENANCE OF EFFORT REQUIREMENT.**

15 “(a) IN GENERAL.—A State is not eligible for pay-
16 ment under any program specified in subsection (c) for
17 a calendar quarter in a plan year beginning after 2027
18 unless the State makes to the Secretary for transfer to
19 the unified Medicare Trust Fund under section 2207 the
20 maintenance of effort payment applicable to such State
21 and plan year under subsection (b). The Secretary shall
22 extend such a waiver (including the availability of Federal
23 financial participation under such waiver) for such period
24 as may be required for a State to meet the requirement
25 of the previous sentence.

1 “(b) MAINTENANCE OF EFFORT PAYMENTS.—For
2 purposes of this section, a maintenance of effort payment
3 with respect to a State and plan year is—

4 “(1) for plan year 2028 and a State, a payment
5 in an amount equal to the total amount of expendi-
6 tures of the State for medical assistance under title
7 XIX and child health assistance under title XXI in-
8 cluding administrative costs for the plan year before
9 the date of the enactment of this title;

10 “(2) for plan year 2029 and each subsequent
11 plan year before plan year 2033—

12 “(A) in the case of a State that is a
13 PPACA expansion State, the payment amount
14 applied under this subsection for the previous
15 plan year, increased by growth in GDP per cap-
16 ita plus 0.4 percent; and

17 “(B) in the case of a State that is not a
18 PPACA expansion State, the payment amount
19 applied under this subsection for the previous
20 plan year, increased by growth in GDP per cap-
21 ita plus 0.7 percent; and

22 “(3) beginning in 2033, for each subsequent
23 plan year, with respect to any State, the payment
24 amount applied under this subsection for the pre-

1 vious year, increased by growth in GDP per capita
2 plus 0.7 percent.

3 “(c) PROGRAMS SPECIFIED.—For purposes of this
4 section, the programs specified in this subsection are each
5 of the following:

6 “(1) Block grants for community mental health
7 services under subpart I of part B of title XIX of
8 the Public Health Service Act.

9 “(2) Block grants and programs for social serv-
10 ices and elder justice under title XX.

11 “(3) Maternal and child health services block
12 grants under title V.

13 “(4) Block grants for prevention and treatment
14 of substance abuse under subpart II of part B of
15 title XIX of the Public Health Service Act.

16 “(5) State Targeted Response to Opioid Crisis
17 Grant Community Services Block Grant.

18 “(6) Grants under section 330 of the Public
19 Health Service Act.

20 “(7) Ryan White HIV/AIDS Program grants
21 under title XXVI of the Public Health Service Act.

22 **“SEC. 2210. APPLICATION OF TITLE XVIII PROVISIONS.**

23 “Except as specified otherwise in this title, in imple-
24 menting Medicare for America, the Secretary shall to the
25 greatest extent practicable apply the following provisions

1 of title XVIII to the program under this title, benefits cov-
2 ered under this title, individuals entitled to benefits under
3 this title, and providers of services and suppliers partici-
4 pating under the program under this title in a similar
5 manner as such provisions applied to the program under
6 title XVIII, benefits covered under such title, individuals
7 entitled to benefits or enrolled under such title, and pro-
8 viders of services and suppliers participating under the
9 program under such title:

- 10 “(1) Section 1801.
- 11 “(2) Section 1805.
- 12 “(3) Section 1806.
- 13 “(4) Section 1807.
- 14 “(5) Section 1809.
- 15 “(6) Section 1814.
- 16 “(7) Section 1815.
- 17 “(8) Section 1816.
- 18 “(9) Section 1818.
- 19 “(10) Section 1818A.
- 20 “(11) Section 1819.
- 21 “(12) Section 1820.
- 22 “(13) Section 1834.
- 23 “(14) Section 1834A.
- 24 “(15) Section 1843.
- 25 “(16) Section 1846.

- 1 “(17) Section 1847.
- 2 “(18) Section 1851.
- 3 “(19) Section 1852.
- 4 “(20) Section 1855.
- 5 “(21) Section 1856.
- 6 “(22) Section 1857.
- 7 “(23) Section 1858.
- 8 “(24) Section 1861.
- 9 “(25) Section 1863.
- 10 “(26) Section 1864.
- 11 “(27) Section 1866B.
- 12 “(28) Section 1866C.
- 13 “(29) Section 1866E.
- 14 “(30) Section 1867.
- 15 “(31) Section 1868.
- 16 “(32) Section 1869.
- 17 “(33) Section 1871.
- 18 “(34) Section 1874A.
- 19 “(35) Section 1880.
- 20 “(36) Section 1881.
- 21 “(37) Section 1881A.
- 22 “(38) Section 1891.
- 23 “(39) Section 1894.
- 24 “(40) Section 1895.
- 25 “(41) Section 1896.

1 **“PART B—HOME AND COMMUNITY BASED LONG-**
2 **TERM SERVICES AND SUPPORTS**

3 **“SEC. 2231. HOME AND COMMUNITY BASED LONG-TERM**
4 **SERVICES AND SUPPORTS BENEFIT.**

5 “All individuals enrolled under Medicare for America
6 under this title shall have coverage for home and commu-
7 nity based long-term services and supports benefits. Noth-
8 ing in this part shall be construed to limit an enrollee’s
9 entitlement to any other benefit that is covered pursuant
10 to section 2203, including nursing facility benefits.

11 **“SEC. 2232. ELIGIBILITY.**

12 “(a) ELIGIBLE INDIVIDUALS.—An individual who is
13 eligible for home and community based long-term services
14 and supports benefits under this part is an individual who
15 satisfies each of the following:

16 “(1) The individual is eligible for Medicare for
17 America.

18 “(2) The individual is determined by a licensed
19 health care practitioner to be unable to perform,
20 without substantial assistance, at least one Activity
21 of Daily Living as described in section
22 7702B(c)(2)(B) of the Internal Revenue Code of
23 1986, or to require substantial assistance with one
24 or more of the following areas:

25 “(A) Communication.

26 “(B) Social interaction.

1 “(C) Learning.

2 “(D) Self-care.

3 “(E) Self-management.

4 “(F) Impairments that affect the person’s
5 capacity for social or economic participation.

6 “(b) CLARIFICATION.—Under this part, in the case
7 of an individual described in subsection (a) who experi-
8 ences periods in which their functional capacity changes
9 or improves, such individual shall continue to have access
10 to benefits under this part as needed. If such an individ-
11 ual’s functional capacity improves to a point in which the
12 individual no longer requires home and community based
13 long-term services and supports, or requires fewer serv-
14 ices, the individual shall be able to immediately and
15 seamlessly resume receiving all needed services if and
16 when their functional needs recur. Eligibility for services
17 shall be maintained if, without the services, the individual
18 would have reduced functional capacity. When assessing
19 functional impairment, the individual will be assessed
20 without regard to any current services or the ameliorative
21 effects of other mitigating measures described in section
22 3(4)(E)(i)(I) of the Americans With Disabilities Act of
23 1990.

24 “(c) BENEFITS.—

1 “(1) DEFINITION.—For purposes of this title,
2 the term ‘home and community based long-term
3 services and supports benefit’ means the daily living
4 supports needed by eligible individuals in order to
5 live, work, and participate in their communities, and
6 includes all home and community based services and
7 supports coverable as of the date of the enactment
8 of this title, under any State plan or waiver under
9 title XIX, including—

10 “(A) home health aides and homemakers;

11 “(B) direct support professionals and per-
12 sonal attendant care services;

13 “(C) hospice;

14 “(D) nursing care;

15 “(E) medical social services;

16 “(F) care coordination, including case
17 management, fiscal intermediary, and support
18 brokerage services;

19 “(G) short-term inpatient care, including
20 respite care and care for pain control;

21 “(H) behavioral health home and commu-
22 nity based long-term services and supports, in-
23 cluding assertive community treatment; peer
24 support services; intensive care coordination, in-

1 including case management; supported employ-
2 ment; and supported housing wraparound;

3 “(I) private-duty nursing;

4 “(J) respite services provided in the indi-
5 vidual’s home or broader community; and

6 “(K) transitional services to support an in-
7 dividual’s transition from an institutional set-
8 ting to the community.

9 “(2) NON-APPLICATION.—The provisions of sec-
10 tions 424.22(a)(1)(i) and 424.22(a)(1)(ii) of title 42
11 of the Code of Federal Regulations does not apply
12 in the case of the benefit described in paragraph
13 (1)(A).

14 “(d) HOME AND COMMUNITY BASED LONG-TERM
15 SERVICES AND SUPPORTS WORKFORCE DEVELOP-
16 MENT.—

17 “(1) IN GENERAL.—The Secretary shall ensure
18 that the number of individuals in the home and com-
19 munity based long-term services and supports work-
20 force is adequate to ensure community integration
21 for all beneficiaries under Medicare for America. In
22 so doing, the Secretary may consider a wide range
23 of factors, including payment rates for direct care
24 workers, career pipelines and credentialing, worker
25 rights, and the impact of national labor policies.

1 “(2) SELF-DIRECTED MODEL.—All eligible indi-
2 viduals shall be defaulted into a self-directed care
3 option (as defined by the Secretary). The Secretary
4 must consult with eligible individuals, caregivers,
5 workers and their representatives, including unions,
6 and state entities responsible for administering the
7 LTSS benefit to establish this model.

8 “(3) COMMUNITY FIRST.—The benefit under
9 this part shall be arranged for and provided with a
10 community first presumption and eligible individuals
11 shall be provided home and community based long-
12 term services and support available under this sec-
13 tion, regardless of type or level of disability or serv-
14 ice need. No eligible individual may be referred to an
15 institution without first being offered and, if chosen,
16 provided home and community based long-term serv-
17 ices and supports. Individuals in an institution on
18 the effective date of the bill, and at least annually
19 or upon any change in condition thereafter, shall be
20 informed of, and if chosen, provided with home and
21 community based long-term services and supports.

22 “(e) ADMINISTRATION OF SERVICES AND SUP-
23 PORTS.—State entities responsible for administering home
24 and community based long-term services and support ben-
25 efits under any State plan or waiver under title XIX as

1 of the date of the enactment of this title shall continue
2 to administer the benefits and services coverable under
3 this section.

4 “(f) COORDINATION WITH OTHER FEDERAL BENE-
5 FITS.—

6 “(1) RULE OF CONSTRUCTION.—Nothing in
7 this part shall be construed as prohibiting benefits
8 paid under this part from being used to compensate
9 a caregiver who provides community living assistance
10 services and supports to a dependent relative for
11 providing community living assistance services and
12 supports to an eligible individual under this part.

13 “(2) DEPENDENT RELATIVE DEFINED.—The
14 term ‘dependent relative’ means a child, grandchild,
15 niece, nephew, parent, grandparent, sibling, aunt, or
16 uncle (of such caregiver or his or her spouse or do-
17 mestic partner); such caregiver’s spouse or domestic
18 partner, if such child, grandchild, niece, nephew,
19 parent, grandparent, sibling, aunt, uncle, spouse, or
20 domestic partner is an eligible individual.

21 “(3) SUPPLEMENT NOT SUPPLANT.—Benefits
22 received under this part by a caregiver shall supple-
23 ment, but not supplant, other benefits for which the
24 individual is eligible under any other federally fund-
25 ed program that provides benefits or assistance.

1 “(4) DISREGARD.—The benefit paid under this
2 part shall be disregarded for purposes of deter-
3 mining or continuing the eligibility of the individual
4 or the spouse of the individual for receipt of benefits
5 under any other Federal, State, or locally funded as-
6 sistance program, including benefits paid under title
7 II or XVI, under the laws administered by the Sec-
8 retary of Veterans Affairs, under low-income hous-
9 ing assistance programs, under the supplemental nu-
10 trition assistance program established under the
11 Food and Nutrition Act of 2008, or under programs
12 administered by State vocational rehabilitation agen-
13 cies.

14 “(5) REGULATIONS.—Not later than one year
15 after the date of the enactment of this section, the
16 Secretary shall promulgate such regulations as are
17 necessary to carry out this part and to prevent fraud
18 and abuse with respect to the benefits under this
19 part.

20 **“PART C—MEDICARE ADVANTAGE FOR AMERICA**

21 **“SEC. 2221. ALL PRIVATE PLANS.**

22 “(a) IN GENERAL.—For plan years beginning with
23 plan year 2023, a health insurance issuer may offer health
24 insurance coverage in the individual market only if such

1 issuer has entered into a contract with the Secretary
 2 under subsection (b) to offer such coverage.

3 “(b) AGREEMENTS.—The Secretary shall enter into
 4 an agreement with an MA for America sponsor to offer
 5 MA for America plans under this part for the coverage
 6 of individuals enrolled under Medicare for America who
 7 elect to receive benefits under part A through such a plan.

8 “(c) MA FOR AMERICA PLAN; MA FOR AMERICA
 9 SPONSOR.—For purposes of this part:

10 “(1) MA FOR AMERICA PLAN.—An MA for
 11 America plan is a Medicare Advantage plan under
 12 part C of title XVIII, except such plan shall provide
 13 coverage for individuals enrolled under Medicare for
 14 America under part A of this title, with respect to
 15 at least the benefits covered under such part A.

16 “(2) MA FOR AMERICA SPONSOR.—An MA for
 17 America sponsor is a sponsor of an MA for America
 18 plan.

19 **“SEC. 2222. APPLICATION OF MEDICARE ADVANTAGE PRO-**
 20 **VISIONS.**

21 “For purposes of applying this part, except as other-
 22 wise specified under this part, the provisions of part C
 23 of title XVIII, as in effect as of the date of the enactment
 24 of this title shall apply with respect to an MA for America
 25 sponsor, MA for America plan, individuals eligible for cov-

1 erage under this part, individuals enrolled under such
2 plan, and benefits covered under part A in a similar man-
3 ner and to a similar extent as such provisions applied to
4 an MA organization, MA plan, individuals eligible for
5 under part C of such title, individuals enrolled under an
6 MA plan, and benefits covered under fee-for-service Medi-
7 care as of such date.

8 **“SEC. 2223. MEDICARE ADVANTAGE FOR AMERICA PAY-**
9 **MENT RATES.**

10 “The rates for Medicare Advantage for America
11 plans shall be equal to the rates paid by Medicare for
12 America. The Administrator of the Center for Healthcare
13 shall pay Medicare Advantage for America plans 95 per-
14 cent of average Medicare for America costs in each county.

15 **“SEC. 2224. SEPARATE PREMIUM FOR MEDICARE ADVAN-**
16 **TAGE FOR AMERICA PLANS FURNISHING**
17 **SUPPLEMENTAL BENEFITS.**

18 “Nothing in this part shall preclude an individual
19 from choosing a Medicare Advantage for America plan
20 which requires the individual to pay an additional, sepa-
21 rate amount because of supplemental benefits or because
22 it is a more expensive plan. In such case the individual
23 enrolled under such plan would be responsible for a sepa-
24 rate monthly premium.

1 **“SEC. 2225. PRESCRIPTION DRUG PRICING UNDER MEDI-**
2 **CARE ADVANTAGE FOR AMERICA PLANS.**

3 “Medicare Advantage for America plans, for prescrip-
4 tion drugs, shall pay no more than the price negotiated
5 under Medicare for America.

6 **“SEC. 2226. BAN ON PAYING BROKERS’ FEES.**

7 “Medicare Advantage for America plans may not pay
8 fees to insurance brokers.

9 **“SEC. 2227. CLARIFICATION ON MEDICARE ADVANTAGE EM-**
10 **PLOYER GROUP WAIVER PLANS AND THE**
11 **MEDICARE SECONDARY PAYER REQUIRE-**
12 **MENT.**

13 “Such plans shall be exempt from the MSP Require-
14 ment, and nothing in this section shall be construed as
15 prohibiting such plans from contributing to the payment
16 of premiums and cost-sharing.

17 **“SEC. 2228. REFERENCES.**

18 “Beginning in 2023, all references in law and regula-
19 tion to Medicare Advantage shall be deemed a reference
20 to Medicare Advantage for America.”.

21 **SEC. 112. MODIFICATIONS TO AND COORDINATION WITH**
22 **EXISTING FEDERAL HEALTH PROGRAMS.**

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

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

1 and section 2202(c) of the Social Security Act, as
2 added by section 111—

3 (A) no benefits shall be available under
4 title XVIII of the Social Security Act for any
5 item or service furnished—

6 (i) beginning on or after January 1,
7 2023 (except in the case of an individual
8 enrolled under such title and title XIX of
9 such Act); and

10 (ii) beginning on or after January 1,
11 2025, with respect to all individuals, in-
12 cluding individuals enrolled under such
13 title and title XIX of such Act;

14 (B) no individual is entitled to medical as-
15 sistance under a State plan approved under
16 title XIX of such Act—

17 (i) for any item or service furnished
18 on or after January 1, 2025, in the case
19 of an individual enrolled under such title
20 and title XVIII of the Social Security Act
21 or an individual described in subclause
22 (VIII) of section 1902(a)(10)(A)(i); and

23 (ii) for any item or service furnished
24 on or after January 1, 2027;

1 (C) no individual is entitled to medical as-
2 sistence under a State child health plan under
3 title XXI of such Act for any item or service
4 furnished on or after January 1, 2025; and

5 (D) no payment shall be made to a State
6 under section 1903(a) or 2105(a) of such Act
7 with respect to medical assistance or child
8 health assistance—

9 (i) for any item or service furnished
10 on or after January 1, 2025, in the case
11 of an individual enrolled under such title
12 and title XVIII of the Social Security Act
13 or an individual described in subclause
14 (VIII) of section 1902(a)(10)(A)(i); and

15 (ii) for any item or service furnished
16 on or after January 1, 2027.

17 (2) TRANSITION.—In the case of inpatient hos-
18 pital services and extended care services during a
19 continuous period of stay which began before Janu-
20 ary 1, 2025, for Medicare and 2027 for Medicaid or
21 CHIP, and which had not ended as of such date, for
22 which benefits are provided under title XVIII of the
23 Social Security Act, under a State plan under title
24 XIX of such Act, or under a State child health plan
25 under title XXI such Act, the Secretary of Health

1 and Human Services shall provide for continuation
2 of benefits under such title or plan until the end of
3 the period of stay.

4 (b) OTHER FEDERAL HEALTH PROGRAMS.—

5 (1) FEDERAL EMPLOYEES HEALTH BENEFITS
6 PROGRAM.—Nothing in this Act, or the amendments
7 made by this Act, shall affect benefits made avail-
8 able under chapter 89 of title 5, United States Code.

9 (2) TRICARE.—Nothing in this Act, or the
10 amendments made by this Act, shall affect benefits
11 made available under sections 1079 and 1086 of
12 title 10, United States Code.

13 (3) TREATMENT OF BENEFITS FOR VETERANS
14 AND NATIVE AMERICANS.—

15 (A) IN GENERAL.—Nothing in this Act, or
16 the amendments made by this Act, shall affect
17 the eligibility of veterans for the medical bene-
18 fits and services provided under title 38, United
19 States Code, or of Indians for the medical bene-
20 fits and services provided by or through the In-
21 dian Health Service.

22 (B) REEVALUATION.—No reevaluation of
23 the Indian Health Service shall be undertaken
24 without consultation with tribal leaders and
25 stakeholders.

1 (C) SUPPLEMENTAL INDIAN HEALTH
2 SERVICES ALLOCATION.—The Secretary shall
3 annually determine the need to provide an allot-
4 ment of supplemental funds to Indian Health
5 Services, including payments to providers,
6 health professional education, administrative ex-
7 penses, and prevention and public health activi-
8 ties.

9 (4) ENROLLEE CHOICE.—Nothing in this Act
10 shall preclude individuals enrolled in the Federal
11 Employees Health Benefits Program or TRICARE
12 or individuals receiving benefits provided under title,
13 38, United States Code or the Indian Health Service
14 from enrolling in Medicare for America. Enrollees
15 shall be entitled to the employer contribution as es-
16 tablished under section 126(c) of such Act.

17 (c) SUNSET OF PROVISIONS RELATED TO THE STATE
18 EXCHANGES.—Effective January 1, 2022, the Federal
19 and State Exchanges established pursuant to title I of the
20 Patient Protection and Affordable Care Act (Public Law
21 111–148) shall terminate, and any other provision of law
22 that relies upon participation in or enrollment through
23 such an Exchange, including such provisions of the Inter-
24 nal Revenue Code of 1986, shall cease to have force or
25 effect.

1 (d) SEVERABILITY.—Every provision in this Act and
2 every application of the provisions in this Act are severable
3 from each other as a matter of Federal law. If any applica-
4 tion of any provision in this Act to any person or group
5 of persons or circumstances is found by a court to be in-
6 valid, the remainder of this Act and the application of the
7 Act’s provisions to all other persons and circumstances
8 may not be affected.

9 **Subtitle C—Targeted Reforms**

10 **SEC. 121. NO SURPRISE BILLING.**

11 (a) SURPRISE BILL DEFINED.—For purposes of this
12 section the term “surprise bill”—

13 (1) means a bill for health care services, other
14 than emergency services, received by an insured for
15 services rendered by an out-of-network health care
16 provider, where such services were rendered by such
17 out-of-network provider at an in-network facility,
18 during a service or procedure performed by an in-
19 network provider or during a service or procedure
20 previously approved or authorized by the health car-
21 rier and the insured did not knowingly elect to ob-
22 tain such services from such out-of-network provider;
23 and

24 (2) does not include a bill for health care serv-
25 ices received by an insured when an in-network

1 health care provider was available to render such
2 services and the insured knowingly elected to obtain
3 such services from another health care provider who
4 was out-of-network.

5 (b) No non-participating health care provider shall
6 require prior authorization for rendering emergency serv-
7 ices to an insured.

8 (c) No health carrier shall impose, for emergency
9 services rendered to an insured by an out-of-network
10 health care provider, a coinsurance, copayment, deductible
11 or other out-of-pocket expense that is greater than the co-
12 insurance, copayment, deductible or other out-of-pocket
13 expense that would be imposed if such emergency services
14 were rendered by an in-network health care provider.

15 (d) PAYMENT AMOUNT.—If emergency services were
16 rendered to an insured by an out-of-network health care
17 provider, such health care provider may bill the health car-
18 rier directly and the health carrier shall reimburse such
19 health care provider the greatest of the following amounts:

20 (1) The amount payable under Medicare for
21 America for such services if rendered by a health
22 care provider participating in Medicare for America.

23 (2) The arbitrated amount between the quali-
24 fying health plan and the non-participating provider.

1 (e) Nothing in this section shall be construed to pro-
2 hibit the qualifying health plan and the non-participating
3 health care provider from agreeing to a greater reimburse-
4 ment amount.

5 (f) NON-EMERGENCY SERVICES.—With respect to a
6 surprise bill, the following applies:

7 (1) An individual enrolled in the qualifying
8 health plan shall only be required to pay the applica-
9 ble coinsurance that would be imposed for such
10 health care services if such services were rendered by
11 a participating health care provider.

12 (2) The qualifying health plan shall reimburse
13 the non-participating health care provider or indi-
14 vidual enrolled in such health plan, as applicable, for
15 health care services rendered at the qualifying health
16 plan rate as payment in full, unless the health plan
17 and the non-participating health care provider agree
18 otherwise.

19 (g) If health care services were rendered to an indi-
20 vidual enrolled in qualifying health coverage by a non-par-
21 ticipating health care provider and the qualifying health
22 plan failed to inform such enrollee, if such enrollee was
23 required to be informed, of the network status of such
24 non-participating health care provider, the qualifying
25 health plan shall not impose coinsurance expense that is

1 greater than the maximum out-of-pocket expense that
2 would be imposed if such services were rendered by a
3 qualifying health care provider.

4 (h) EMERGENCY SERVICES.—

5 (1) NO PRIOR AUTHORIZATION.—A health care
6 provider not participating in Medicare for America
7 may not require prior authorization for rendering
8 emergency services to an individual enrolled under
9 Medicare for America.

10 (2) OUT-OF-POCKET EXPENSES.—A health care
11 provider not participating in Medicare for America
12 may not impose, for emergency services rendered to
13 an individual enrolled in Medicare for America, a co-
14 insurance, copayment, or other out-of-pocket expense
15 that is greater than the coinsurance or maximum
16 out-of-pocket expense that would be imposed if such
17 emergency services were rendered by a Medicare for
18 America participating provider.

19 (3) PAYMENT AMOUNT.—If emergency services
20 are rendered to an individual enrolled in Medicare
21 for America by a health care provider not partici-
22 pating in Medicare for America, such health care
23 provider may bill Medicare for America directly and
24 Medicare for America shall reimburse such health
25 care provider the greatest of the following amounts:

1 (A) The amount payable under Medicare
2 for America for such services if rendered by a
3 health care provider participating in Medicare
4 for America.

5 (B) The arbitrated amount between the
6 Secretary of Health and Human Services and
7 the provider, determined by an arbitration proc-
8 ess established by the Secretary.

9 (i) NON-EMERGENCY SERVICES.—With respect to a
10 surprise bill, the following applies:

11 (1) An individual enrolled in qualifying coverage
12 (as defined in section 2202(b)(4)(B) of the Social
13 Security Act) shall only be required to pay the appli-
14 cable coinsurance that would be imposed for such
15 health care services if such services were rendered by
16 a health care provider participating in Medicare for
17 America.

18 (2) The Secretary of Health and Human Serv-
19 ices shall reimburse the non-participating health
20 care provider or individual enrolled in such health
21 plan, as applicable, for health care services rendered
22 at rate payable under Medicare for America as pay-
23 ment in full, unless the Secretary and the non-par-
24 ticipating health care provider agree otherwise.

1 (3) If health care services were rendered to an
 2 individual enrolled in Medicare for America by a
 3 health care provider not participating in Medicare
 4 for America and the Secretary of Health and
 5 Human Services failed to inform such enrollee, if
 6 such enrollee was required to be informed, of the
 7 network status of such non-participating health care
 8 provider, the Secretary shall not impose a coinsur-
 9 ance expense that is greater than the maximum out-
 10 of-pocket expense that would be imposed if such
 11 services were rendered by a provider participating in
 12 Medicare for America.

13 **SEC. 122. LIMITATION ON REMOVAL OF MEDICARE ADVAN-**
 14 **TAGE PROVIDERS BY MA ORGANIZATIONS.**

15 (a) LIMITATION.—Section 1852(d) of the Social Se-
 16 curity Act (42 U.S.C. 1395w–22(d)) is amended by adding
 17 at the end the following:

18 “(7) LIMITATION ON REMOVAL OF PROVIDERS
 19 FROM MA PLANS BY MA ORGANIZATIONS.—

20 “(A) REMOVAL OF PROVIDERS WITH
 21 CAUSE.—Beginning with plan year 2020, except
 22 as provided in subparagraph (C), an MA orga-
 23 nization offering an MA plan may only remove
 24 a provider of services or a supplier from a net-

1 work of such plan if the organization has cause
2 to remove such provider or supplier.

3 “(B) CAUSE TO REMOVE PROVIDERS.—

4 “(i) IN GENERAL.—An MA organiza-
5 tion offering an MA plan has cause to re-
6 move a provider of services or a supplier
7 from a network of such plan if the Sec-
8 retary determines that the provider or sup-
9 plier is—

10 “(I) medically negligent;

11 “(II) in violation of any legal or
12 contractual requirement applicable to
13 the provider or supplier acting within
14 the lawful scope of practice, including
15 any participation or other requirement
16 applicable to such provider or supplier
17 under this title or under any contrac-
18 tual term for such plan; or

19 “(III) otherwise unfit to furnish
20 items and services in accordance with
21 requirements of this title.

22 “(ii) CONSIDERATION OF COST TO MA
23 ORGANIZATIONS.—For purposes of sub-
24 paragraph (A), cost to an MA organization
25 offering an MA plan due to the participa-

1 tion of a provider of services or supplier in
2 a network of such plan does not constitute
3 cause for the MA organization to remove
4 such provider or supplier from the network
5 mid-year, and such cost may not be consid-
6 ered as a factor in favor of a determination
7 that such organization has cause to remove
8 the provider.

9 “(C) EXCEPTION.—With respect to each
10 upcoming plan year, beginning with plan year
11 2020 an MA organization offering an MA plan
12 may only remove a provider of services or sup-
13 plier from a network of such plan for reasons
14 not specified in subparagraph (B)(i) before the
15 date that is 60 days before the first day of the
16 annual coordinated election period for such plan
17 year under section 1851(e)(3).

18 “(D) NOTICE AND APPEAL PROCESS.—

19 “(i) IN GENERAL.—Any removal of a
20 provider of services or supplier from a net-
21 work of an MA plan may occur only after
22 the completion of a fair notice and appeal
23 process that the Secretary shall establish
24 by regulation. Such process shall require
25 the MA organization to provide to such

1 provider or supplier and to the Secretary
2 an explanation of the reason or reasons for
3 the removal. The Secretary shall make this
4 information publicly available.

5 “(ii) APPLICATION.—

6 “(I) APPLICATION OF NEW PROC-
7 ESS.—In the case of a removal of a
8 provider of services or supplier from a
9 network of an MA plan occurring on
10 or after the effective date published in
11 a final rule for such fair notice and
12 appeal process, such process shall
13 apply in lieu of the process for the
14 termination or suspension of a pro-
15 vider contract under section
16 422.202(a) of title 42, Code of Fed-
17 eral Regulations.

18 “(II) CONTINUATION OF OLD
19 PROCESS.—In the case of a removal of
20 a provider of services or supplier from
21 a network of an MA plan occurring
22 before such effective date, the process
23 for the termination or suspension of a
24 provider contract under section

1 422.202(a) of title 42, Code of Fed-
2 eral Regulations, shall apply.

3 “(E) PARTICIPANT NOTICE AND PROTEC-
4 TION.—

5 “(i) NOTICE TO PARTICIPANTS OF
6 PROVIDER REMOVAL.—Not less than 60
7 days before the date on which a provider
8 of services or supplier is removed from a
9 network of an MA plan, the MA organiza-
10 tion offering such plan shall provide writ-
11 ten notification of the removal to each in-
12 dividual enrolled in such plan receiving
13 items or services from the provider or sup-
14 plier during the plan year in effect on the
15 date of removal or during the previous
16 plan year. Such notification shall include
17 at the minimum—

18 “(I) the names and telephone
19 numbers of available in-network pro-
20 viders of services and suppliers offer-
21 ing items and services that are the
22 same or similar to the items and serv-
23 ices offered by the removed provider
24 or supplier;

1 “(II) information regarding the
2 options available to an individual en-
3 rolled in such plan to request the con-
4 tinuation of medical treatment or
5 therapy with the removed provider or
6 supplier; and

7 “(III) one or more customer serv-
8 ice telephone numbers that an indi-
9 vidual enrolled in such plan may ac-
10 cess to obtain information regarding
11 changes to the network of the plan.

12 “(ii) ANNUAL NOTICE OF CHANGE.—

13 In addition to providing the notification of
14 removal as required under clause (i), the
15 MA organization offering such MA plan
16 shall include such notification in the an-
17 nual notice of change for the MA plan for
18 the upcoming plan year.

19 “(iii) CONTINUITY OF CARE.—In any
20 case in which a provider of services or sup-
21 plier is removed from a network of an MA
22 plan, such plan shall ensure that the re-
23 moval satisfies the continuity of care re-
24 quirements under paragraph (1)(A) with
25 respect to each individual enrolled in such

1 plan receiving items or services from the
2 provider or supplier during the plan year
3 in effect on the date of removal or during
4 the previous plan year.

5 “(F) RULE OF CONSTRUCTION.—Nothing
6 in this paragraph shall be construed as affect-
7 ing the ability of a provider of services or sup-
8 plier to decline to participate in a network of an
9 MA plan.

10 “(8) TRANSPARENCY IN MEASURES USED BY
11 MA ORGANIZATIONS TO ESTABLISH OR MODIFY PRO-
12 VIDER NETWORKS.—

13 “(A) IN GENERAL.—Beginning with plan
14 year 2020, an MA organization offering an MA
15 plan shall publish and make accessible the in-
16 formation described in subparagraph (B)—

17 “(i) in the annual bid information
18 submitted by the MA organization with re-
19 spect to the MA plan under section 1854;
20 and

21 “(ii) on the Internet Web Site for the
22 MA plan.

23 “(B) INFORMATION DESCRIBED.—The in-
24 formation described in this subparagraph is the
25 following:

1 “(i) Information regarding the meas-
 2 ures used by the MA organization to estab-
 3 lish or modify the provider network of the
 4 MA plan, including measures of the quality
 5 and efficiency of providers. Such informa-
 6 tion shall include the specifications, meth-
 7 odology, and sample size of such measures.

8 “(ii) Other information related to the
 9 establishment or modification of such pro-
 10 vider network that the Secretary deter-
 11 mines appropriate.

12 “(C) LIMITATION.—The information de-
 13 scribed in subparagraph (B) shall not include
 14 any individually identifiable information of any
 15 provider or supplier of services.”.

16 (b) ENFORCEMENT.—

17 (1) SANCTIONS FOR NONCOMPLIANCE.—Section
 18 1857(g)(1) of the Social Security Act (42 U.S.C.
 19 1395w–27(g)(1)) is amended—

20 (A) in subparagraph (J), by striking “or”;

21 (B) by redesignating subparagraph (K) as
 22 subparagraph (L);

23 (C) by inserting after subparagraph (J)
 24 the following new subparagraph:

1 “(K) fails to comply with section
2 1852(d)(7) or 1852(d)(8); or”; and

3 (D) in subparagraph (L) (as so redesign-
4 nated), by striking “through (J)” and inserting
5 “through (K)”.

6 (2) SANCTIONS NOT APPLICABLE TO PART D.—

7 Title XVIII of the Social Security Act is amended—

8 (A) in section 1860D–12(b)(3)(E) (42
9 U.S.C. 1395w–112(b)(3)(E)), by striking
10 “paragraph (1)(F)” and inserting “paragraphs
11 (1)(F) and (1)(K)”; and

12 (B) in section 1894(e)(6)(B) (42 U.S.C.
13 1395eee(e)(6)(B)), by inserting “(other than
14 paragraph (1)(K) of such section)” after
15 “1857(g)(1)”.

16 (c) MEDICARE ADVANTAGE PLAN COMPARE TOOL.—

17 Not later than one year after the date of enactment of
18 this Act, the Secretary of Health and Human Services
19 shall take such measures as are necessary to ensure that
20 the Medicare Advantage Compare Tool takes into account
21 the preferences and utilization needs of such individuals.

22 **SEC. 123. NETWORK ADEQUACY.**

23 (a) IN GENERAL.—Section 1852(d) of the Social Se-
24 curity Act (42 U.S.C. 1395w–22(d)) is amended by adding
25 at the end the following:

1 “(9) NETWORK ADEQUACY REQUIREMENTS.—
2 Beginning in plan year 2019, notwithstanding any
3 other provision of law, the following shall apply:

4 “(A) PROVIDER AVAILABILITY.—When es-
5 tablishing a plan network, a Medicare Advan-
6 tage organization offering an MA plan shall,
7 among other factors determined by the Sec-
8 retary, consider the following:

9 “(i) The anticipated enrollment in the
10 plan.

11 “(ii) The expected types of services
12 provided and utilization of services by en-
13 rollees under the plan.

14 “(iii) The number and types of pro-
15 viders needed to provide such services.

16 “(iv) The number of network pro-
17 viders who are not accepting new patients.

18 “(v) The location of providers and en-
19 rollees, taking into account geographic dis-
20 bursement.

21 “(vi) The full-time equivalent avail-
22 ability of a provider to provide such serv-
23 ices.

24 “(B) PROVISION OF CARE IN A TIMELY
25 MANNER.—A Medicare Advantage organization

1 offering an MA plan shall ensure that providers
2 are able to provide services in a timely manner,
3 as defined by the Secretary, under the plan.

4 “(C) APPLICATION OF NETWORK ACCESS
5 ADEQUACY STANDARDS.—In applying the net-
6 work access adequacy standards pursuant to
7 paragraph (1), the Secretary shall seek input
8 from patient advocacy groups, providers of serv-
9 ices and suppliers, and MA plans under this
10 part.

11 “(D) CERTIFICATION.—Each plan year, a
12 Medicare Advantage organization shall certify
13 to the Secretary, with respect to each MA plan
14 offered by the organization, that the providers,
15 including specialists and subspecialists, in the
16 plan network are able to provide the services re-
17 quired under the organization’s contract with
18 the Secretary under section 1857 with respect
19 to the offering of such plan and to meet the
20 needs of the enrollees within the plan service
21 area during the year.

22 “(E) ANNUAL REPORTING.—Each plan
23 year, a Medicare Advantage organization shall
24 report to the Secretary, and make public the

1 following with respect to each MA plan offered
2 by the organization:

3 “(i) AVERAGE WAIT TIME.—The aver-
4 age wait time for primary and specialty
5 care for enrollees under the plan.

6 “(ii) UTILIZATION OF OUT OF NET-
7 WORK PROVIDERS.—The utilization of out-
8 of-network providers under the plan.

9 “(iii) AVERAGE COST PER PATIENT.—
10 The average annual spending per patient
11 for primary and specialty care for enrollees
12 under the plan.

13 “(F) CERTIFICATION.—In advance of the
14 annual, coordinated election period under sec-
15 tion 1851(e)(3), a Medicare Advantage organi-
16 zation shall certify to the Secretary the accu-
17 racy of provider directories for each plan of-
18 fered by the organization.

19 “(G) NETWORK REVIEW.—The Secretary
20 shall ensure that the network of each MA plan
21 offered by a Medicare Advantage organization
22 meets the network adequacy guidelines estab-
23 lished under this paragraph and under section
24 422.112(a)(4) of title 42, Code of Federal Reg-
25 ulations (or any successor regulation to such

1 section) at least once every 3 years or when a
 2 material change in network occurs.

3 “(H) AUTHORITY.—The Secretary shall
 4 have the authority to stop any further enroll-
 5 ment in a Medicare Advantage plan if there is
 6 a pattern of excessive violations of this para-
 7 graph.”.

8 (b) ENFORCEMENT.—Section 1857(g)(1)(K) of the
 9 Social Security Act (42 U.S.C. 1395w–27(g)(1)(K)), as
 10 added by section 2(b), is amended by striking “or
 11 1852(d)(8)” and inserting “, 1852(d)(8), or 1852(d)(9)”.

12 **SEC. 124. ELIMINATING THE 24-MONTH WAITING PERIOD**
 13 **FOR MEDICARE COVERAGE FOR INDIVID-**
 14 **UALS WITH DISABILITIES.**

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

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

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

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

24 (4) in the first sentence, by striking “for each
 25 month beginning with the later of (I) July 1973 or

1 (II) the twenty-fifth month of his entitlement or sta-
 2 tus as a qualified railroad retirement beneficiary de-
 3 scribed in paragraph (2), and” and inserting “for
 4 each month for which the individual meets the re-
 5 quirements of paragraph (2), beginning with the
 6 month following the month in which the individual
 7 meets the requirements of such paragraph, and”;
 8 and

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

12 (b) CONFORMING AMENDMENTS.—

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

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

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

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

23 (3) MEDICARE COVERAGE.—Section 1837(g)(1)
 24 of the Social Security Act (42 U.S.C. 1395p(g)(1))

1 is amended by striking “25th month of” and insert-
2 ing “month following the first month of”.

3 (4) RAILROAD RETIREMENT SYSTEM.—Section
4 7(d)(2)(ii) of the Railroad Retirement Act of 1974
5 (45 U.S.C. 231f(d)(2)(ii)) is amended—

6 (A) by striking “has been entitled to an
7 annuity” and inserting “is entitled to an annu-
8 ity”;

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

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

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to insurance benefits under title
15 XVIII of the Social Security Act with respect to items and
16 services furnished in months beginning after the date of
17 enactment of this Act.

18 **SEC. 125. ELIMINATING THE WAITING PERIOD FOR INDIVIDUALS ON STATE MEDICAID WAITING**
19 **LISTS.**
20

21 The Secretary of Health and Human Services is ap-
22 propriated such sums as are necessary to facilitate enroll-
23 ment, not later than 90 days after the date of the enact-
24 ment of this Act, all eligible individuals who, as of the

1 date of the enactment of this Act, are on State Medicaid
2 waiting lists or State Medicaid waiver waiting lists.

3 **SEC. 126. EMPLOYER HEALTH PLAN OPTIONS.**

4 (a) DEFINITION.—A qualifying employer-sponsored
5 plan is—

6 (1) a governmental plan (within the meaning of
7 section 2791(d)(8) of the Public Health Service
8 Act); or

9 (2) any other plan or coverage that meets the
10 criteria under subsection (b), includes vision, dental,
11 and hearing benefits, and provides health coverage
12 that is equivalent to an actuarial value of at least 80
13 percent of the coverage provided under title XXII of
14 the Social Security Act and makes a premium con-
15 tribution of at least 70 percent.

16 Such plan shall require a premium contribution from the
17 employer of at least 70 percent regardless of whether cov-
18 erage is for single, spousal, or dependent care.

19 (b) OBLIGATION.—Large employers shall, with re-
20 spect to any full-time employee of such employer—

21 (1) offer a qualifying employer-sponsored plan
22 to such employee, in accordance with subsection (a);
23 or

1 (2) make a contribution of 8 percent of their
2 annual payroll to the Medicare Trust Fund under
3 title XXII of the Social Security Act.

4 (c) EMPLOYEE CHOICE.—An employee may opt out
5 of a qualifying employer-sponsored plan as satisfied by
6 subsection (b)(1) in order to enroll in Medicare for Amer-
7 ica. The employer shall make a contribution equal to the
8 contribution it shall make in order to meet the require-
9 ments established by subsection (a)(1) or (a)(2). The Sec-
10 retary of Health and Human Services shall have authority
11 to set standards for determining whether employers or in-
12 surers are undertaking any actions to affect the risk pool
13 within Medicare for America by inducing individuals to de-
14 cline coverage under a qualifying employer-sponsored plan
15 and instead to enroll in Medicare for America. An em-
16 ployer violating such standards shall be treated as not
17 meeting the requirements of subsection (a).

18 (d) EMPLOYEE EDUCATION ON HEALTH COVERAGE
19 OPTIONS.—Large employers shall disseminate to employ-
20 ees such publicly available information on coverage options
21 under Medicare for America as the Secretary deems ap-
22 propriate, including contact information for assistance.

23 (e) SPECIAL RULES.—

24 (1) ANNUAL PAYROLL.—For purposes of this
25 paragraph, the term “annual payroll” means, with

1 respect to any employer for any calendar year, the
2 aggregate wages paid by the employer during such
3 calendar year.

4 (2) AGGREGATION RULES.—Related employers
5 and predecessors shall be treated as a single em-
6 ployer for purposes of this subsection.

7 (3) REDUCTION FOR PART-TIME EMPLOYEES.—
8 In the case of a part-time employee, the employer
9 contribution requirements of paragraph (1) shall be
10 treated as satisfied if the employer contribution with
11 respect to such employee is not less than the part-
12 time employment ratio of the contribution required
13 under paragraph (1).

14 (4) RULES RELATED TO PART-TIME EMPLOY-
15 MENT.—For purposes of this subsection—

16 (A) PART-TIME EMPLOYEE.—The term
17 “part-time employee” means, with respect to
18 any month, an employee who works on average
19 fewer than 30 hours per week.

20 (B) PART-TIME EMPLOYMENT RATIO.—
21 The term “part-time employment ratio” means,
22 with respect to a part-time employee of an em-
23 ployer in a month, a fraction—

1 (i) the numerator of which is the
2 number of hours in the employee's normal
3 work week; and

4 (ii) the denominator of which is 30
5 hours.

6 (C) SPECIAL RULES.—Under rules pre-
7 scribed by the Secretary of Health and Human
8 Services, in consultation with the Secretary of
9 the Treasury, in the case of an employee for an
10 employer whose defined work week for full-time
11 employees is less than 30 hours, any reference
12 in this subsection to 30 hours is deemed a ref-
13 erence to the number of hours in the work week
14 so defined.

15 (D) CONVERSION TO HOURS OF EMPLOY-
16 MENT.—The Secretary of Health and Human
17 Services, in consultation with the Secretary of
18 the Treasury, shall establish rules for the con-
19 version of compensation to hours of employ-
20 ment, for purposes of this subsection in the
21 case of employees that receive compensation on
22 a salaried basis, or on the basis of a commis-
23 sion, or other contingent or bonus basis, rather
24 than based on an hourly wage.

1 (f) TIMING AND MANNER.—Each employer that
2 makes a financial contribution under subsection (b)(2)
3 and (c) under this section (other than with respect to cov-
4 erage under a group health plan) shall pay such contribu-
5 tion in a form and manner, specified by the Secretary of
6 the Treasury, based upon the form and manner in which
7 employer excise taxes are required to be paid under section
8 3111 of the Internal Revenue Code of 1986.

9 (g) NON-DISCRIMINATION.—

10 (1) IN GENERAL.—Except as otherwise pro-
11 vided for in this title (or an amendment made by
12 this title), an individual shall not, on the ground
13 prohibited under title VI of the Civil Rights Act of
14 1964 (42 U.S.C. 2000d et seq.), title IX of the Edu-
15 cation Amendments of 1972 (20 U.S.C. 1681 et
16 seq.), the Age Discrimination Act of 1975 (42
17 U.S.C. 6101 et seq.), or section 504 of the Rehabili-
18 tation Act of 1973 (29 U.S.C. 794), be excluded
19 from participation in, be denied the benefits of, or
20 be subjected to discrimination under, any health pro-
21 gram or activity, any part of which is receiving Fed-
22 eral financial assistance, including credits, subsidies,
23 or contracts of insurance, or under any program or
24 activity that is administered by an Executive Agency

1 or any entity established under this title (or amend-
2 ments) or any employer-sponsored insurance.

3 (2) CONTINUED APPLICATION OF LAWS.—Noth-
4 ing in this title (or an amendment made by this
5 title) shall be construed to invalidate or limit the
6 rights, remedies, procedures, or legal standards
7 available to individuals aggrieved under title VI of
8 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
9 seq.), title VII of the Civil Rights Act of 1964 (42
10 U.S.C. 2000e et seq.), title IX of the Education
11 Amendments of 1972 (20 U.S.C. 1681 et seq.), sec-
12 tion 504 of the Rehabilitation Act of 1973 (29
13 U.S.C. 794), or the Age Discrimination Act of 1975
14 (42 U.S.C. 611 et seq.), or to supersede State laws
15 that provide additional protections against discrimi-
16 nation on any basis described in paragraph (1).

17 (3) LIMITATION.—A group health plan may not
18 establish rules relating to the health insurance cov-
19 erage eligibility (including continued eligibility) or
20 contribution requirements of any full-time employee
21 under the terms of the plan that have the effect of
22 discriminating in favor of higher-wage employees.

23 (4) REGULATIONS.—The Secretary of Health
24 and Human Services, in conjunction with the Sec-

1 retary of Labor, may promulgate regulations to im-
2 plement this subsection.

3 **SEC. 127. PROHIBITION ON STEP THERAPY AND PRIOR AU-**
4 **THORIZATION UNDER GROUP HEALTH**
5 **PLANS.**

6 Section 2719A of the Public Health Service Act (42
7 U.S.C. 300gg–19a) is amended by adding at the end the
8 following new subsection:

9 “(e) PROHIBITION AGAINST STEP THERAPY AND
10 PRIOR AUTHORIZATION.—Beginning with the first plan
11 year following the date of the enactment of this subsection,
12 a group health plan may not require a prior authorization
13 determination for coverage of any benefit under such plan
14 and may not apply treatment limitations through the use
15 of step therapy protocols.”.

16 **SEC. 128. MEDICARE OUTPATIENT OBSERVATION SERV-**
17 **ICES.**

18 Section 1861(i) of the Social Security Act (42 U.S.C.
19 1395x(i)) is amended by adding at the end the following:
20 “For purposes of this subsection, an individual receiving
21 outpatient observation services shall be deemed to be an
22 inpatient during such period, and the date such individual
23 ceases receiving such services shall be deemed the hospital
24 discharge date (unless such individual is admitted as a
25 hospital inpatient at the end of such period)”.

1 **SEC. 129. ABORTION COVERAGE.**

2 Notwithstanding any other provision of law, Federal
3 funds may be used to provide for abortion services under
4 any health program or activity.

5 **SEC. 130. APPLICABILITY OF MENTAL HEALTH PARITY.**

6 Section 2726 of the Public Health Service Act shall
7 apply to all health coverage in the same manner and to
8 the same extent as such section applies to health insurance
9 issuers and group health plans under title XXVII of such
10 Act.

11 **SEC. 131. STUDENT LOAN FORGIVENESS FOR HEALTH CARE**
12 **PROVIDERS PARTICIPATING IN MEDICARE**
13 **FOR AMERICA.**

14 (a) IN GENERAL.—Beginning on the date after the
15 date of the enactment of this Act, after the conclusion of
16 each plan year, the Secretary of Health and Human Serv-
17 ices, in conjunction with the Secretary of Education, shall
18 cancel the applicable percent specified in subsection (b)
19 of the total amount due on any eligible Federal Loan made
20 20 years prior to date of enactment and any date after
21 the date of enactment of this Act for a borrower who is
22 a Medicare for America participating provider and sub-
23 mits an employment certification form described in sub-
24 section (d).

25 (b) APPLICABLE PERCENT.—For purposes of sub-
26 section (a), the applicable percent is 10 percent of any

1 eligible Federal Loan for each year the health care pro-
2 vider participates in Medicare for America.

3 (c) DEFINITIONS.—In this section:

4 (1) ELIGIBLE FEDERAL LOAN.—The term “eli-
5 gible Federal loan” means any loan made under part
6 D of title IV of the Higher Education Act of 1965
7 (20 U.S.C. 1087a).

8 (2) HEALTH CARE PROVIDER.—The term
9 “health care provider” means a physician, physician
10 assistant, registered nurse, nurse practitioner, ad-
11 vanced practice nurse, licensed practical nurse, psy-
12 chologist, mental health counselor, marriage and
13 family therapist, direct care worker, health social
14 worker, dentist, dental hygienist, pharmacist, phys-
15 ical therapist, occupational therapist, or any other
16 health care provider specified by the Secretary of
17 Health and Human Services if the Secretary deter-
18 mines such specification for purposes of this section
19 is necessary to ensure workforce adequacy.

20 (3) MEDICARE FOR AMERICA PARTICIPATING
21 PROVIDER.—The term “Medicare for America par-
22 ticipating provider” means a health care provider
23 that meets the definition of such term under section
24 105 or works at a participating provider or entity as
25 defined under section 105.

1 (d) EMPLOYMENT CERTIFICATION FORM.—

2 (1) IN GENERAL.—In order to receive loan can-
3 cellation under this paragraph, a borrower shall sub-
4 mit to the Secretary of Education an employment
5 certification form that is developed by the Secretary
6 of Education and includes self-certification of em-
7 ployment and a separate part for employer certifi-
8 cation that indicates the dates of employment.

9 (2) DEFERMENT.—If a borrower submits to the
10 Secretary of Education the employment certification
11 form described in paragraph (1), during the period
12 in which the borrower is employed as a Medicare for
13 America participating provider for which loan can-
14 cellation is eligible under this section, the borrower's
15 eligible Federal Direct Loan shall be placed in
16 deferment.

17 (e) INTEREST CANCELED.—If a portion of a loan is
18 canceled under this section for any year, the entire amount
19 of interest on such loan that accrues for such year shall
20 be canceled.

21 (f) REGULATIONS.—The Secretary of Health and
22 Human Services and Secretary of Education may promul-
23 gate regulations to implement this section.

1 **SEC. 132. CLARIFICATION OF THE DEFINITION OF PEDI-**
2 **ATRIC MEDICAL NECESSITY IN QUALIFYING**
3 **GROUP COVERAGE.**

4 (a) DEFINITION.—The following definition of pedi-
5 atric medical necessity shall be incorporated into benefit
6 standards of all plans subject to the requirements of sec-
7 tion 1302 of the Patient Protection and Affordable Care
8 Act (42 U.S.C. 18022) and all group plans by 2023.

9 (b) DEVELOPMENT OF DEFINITION.—Pediatric med-
10 ical necessity, or pediatric medically necessary care, shall
11 be defined as health care interventions that are evidence
12 based, evidence informed, or based on consensus advisory
13 opinion and that are recommended by recognized health
14 care professionals, to promote optimal growth and devel-
15 opment in a child and to prevent, detect, diagnose, treat,
16 ameliorate, or palliate the effects of physical, genetic, con-
17 genital, developmental, behavioral, or mental conditions,
18 injuries, or disabilities.

19 (c) UPDATES TO DEFINITION.—The Secretary of
20 Health and Human Services, in consultation with experts
21 in the field of pediatric care and key stakeholders, includ-
22 ing patient and family groups, shall review and update this
23 definition on a biennial basis, consistent with up-to-date
24 standards of pediatric healthcare practice that are based
25 on—

1 (1) the views of pediatric healthcare providers
2 and experts practicing in relevant clinical areas;

3 (2) recommendations of medical-specialty soci-
4 eties, other pediatric healthcare provider organiza-
5 tions, and family and patient groups, and

6 (3) credible scientific evidence published in
7 peer-reviewed literature that is generally recognized
8 by the relevant health care provider community.

9 **SEC. 133. SAFE STAFFING REQUIREMENTS.**

10 (a) MINIMUM DIRECT CARE REGISTERED NURSE
11 STAFFING REQUIREMENTS.—The Public Health Service
12 Act (42 U.S.C. 201 et seq.) is amended by adding at the
13 end the following new title:

14 **“TITLE XXXIV—MINIMUM DI-**
15 **RECT CARE REGISTERED**
16 **NURSE STAFFING REQUIRE-**
17 **MENT**

18 **“SEC. 3401. MINIMUM NURSE STAFFING REQUIREMENT.**

19 **“(a) STAFFING PLAN.—**

20 **“(1) IN GENERAL.—**A hospital shall implement
21 a staffing plan that—

22 **“(A)** provides adequate, appropriate, and
23 quality delivery of health care services and pro-
24 tects patient safety; and

1 “(B) is consistent with the requirements of
2 this title.

3 “(2) EFFECTIVE DATES.—

4 “(A) IMPLEMENTATION OF STAFFING
5 PLAN.—Subject to subparagraph (B), the re-
6 quirements under paragraph (1) shall take ef-
7 fect on a date to be determined by the Sec-
8 retary, but not later than 1 year after the date
9 of the enactment of this title.

10 “(B) APPLICATION OF MINIMUM DIRECT
11 CARE REGISTERED NURSE-TO-PATIENT RA-
12 TIOS.—The requirements under subsection (b)
13 shall take effect as soon as practicable, as de-
14 termined by the Secretary, but not later than—

15 “(i) 2023; and

16 “(ii) in the case of a hospital in a
17 rural area (as defined in section
18 1886(d)(2)(D) of the Social Security Act),
19 2025.

20 “(b) MINIMUM DIRECT CARE REGISTERED NURSE-
21 TO-PATIENT RATIOS.—

22 “(1) IN GENERAL.—Except as provided in para-
23 graph (4) and other provisions of this section, a hos-
24 pital’s staffing plan shall provide that, at all times
25 during each shift within a unit of the hospital, and

1 with a full complement of ancillary and support
2 staff, a direct care registered nurse may be assigned
3 to not more than the following number of patients
4 in that unit:

5 “(A) One patient in trauma emergency
6 units.

7 “(B) One patient in operating room units,
8 provided that a minimum of 1 additional person
9 serves as a scrub assistant in such unit.

10 “(C) Two patients in critical care units, in-
11 cluding neonatal intensive care units, emer-
12 gency critical care and intensive care units,
13 labor and delivery units, coronary care units,
14 acute respiratory care units, postanesthesia
15 units, and burn units.

16 “(D) Three patients in emergency room
17 units, pediatrics units, stepdown units, telem-
18 etry units, antepartum units, and combined
19 labor, deliver, and postpartum units.

20 “(E) Four patients in medical-surgical
21 units, intermediate care nursery units, acute
22 care psychiatric units, and other specialty care
23 units.

24 “(F) Five patients in rehabilitation units
25 and skilled nursing units.

1 “(G) Six patients in postpartum (3 cou-
2 plets) units and well-baby nursery units.

3 “(2) SIMILAR UNITS WITH DIFFERENT
4 NAMES.—The Secretary may apply minimum direct
5 care registered nurse-to-patient ratios established in
6 paragraph (1) for a hospital unit referred to in such
7 paragraph to a type of hospital unit not referred to
8 in such paragraph if such type of hospital unit pro-
9 vides a level of care to patients whose needs are
10 similar to the needs of patients cared for in the hos-
11 pital unit referred to in such paragraph.

12 “(3) APPLICATION OF RATIOS TO HOSPITAL
13 NURSING PRACTICE STANDARDS.—

14 “(A) IN GENERAL.—A patient assignment
15 may be included in the calculation of the direct
16 care registered nurse-to-patient ratios required
17 in this subsection only if care is provided by a
18 direct care registered nurse and the provision of
19 care to the particular patient is within that di-
20 rect care registered nurse’s competence.

21 “(B) DEMONSTRATION OF UNIT-SPECIFIC
22 COMPETENCE.—A hospital shall not assign a di-
23 rect care registered nurse to a hospital unit un-
24 less that hospital determines that the direct
25 care registered nurse has demonstrated current

1 competence in providing care in that unit, and
2 has also received orientation to that hospital's
3 unit sufficient to provide competent care to pa-
4 tients in that unit.

5 “(C) DUTIES OF THE ASSIGNED DIRECT
6 CARE REGISTERED NURSE.—Each patient shall
7 be assigned to a direct care registered nurse
8 who shall directly provide the assessment, plan-
9 ning, supervision, implementation, and evalua-
10 tion of the nursing care provided to the patient
11 at least every shift and has the responsibility
12 for the provision of care to a particular patient
13 within his or her scope of practice.

14 “(D) NURSE ADMINISTRATORS AND SU-
15 PERVISORS.—A registered nurse who is a nurse
16 administrator, nurse supervisor, nurse manager,
17 charge nurse, case manager, or any other hos-
18 pital administrator or supervisor, shall not be
19 included in the calculation of the direct care
20 registered nurse-to-patient ratio unless that
21 nurse has a current and active direct patient
22 care assignment and provides direct patient
23 care in compliance with the requirements of this
24 section, including competency requirements.
25 The exemption in this subsection shall apply

1 only during the hours in which the individual
2 registered nurse has the principal responsibility
3 of providing direct patient care and has no ad-
4 ditional job duties as would a direct care reg-
5 istered nurse.

6 “(E) OTHER PERSONNEL.—Other per-
7 sonnel may perform patient care tasks based on
8 their training and demonstrated skill but may
9 not perform or assist in direct care registered
10 nurse functions unless authorized to do in ac-
11 cordance with State scope of practice laws and
12 regulations.

13 “(F) TEMPORARY NURSING PERSONNEL.—
14 A hospital shall not assign any nursing per-
15 sonnel from temporary nursing agencies patient
16 care to any hospital unit without such personnel
17 having demonstrated competence on the as-
18 signed unit and received orientation to that hos-
19 pital’s unit sufficient to provide competent care
20 to patients in that unit.

21 “(G) ANCILLARY AND ADDITIONAL STAFF-
22 ING.—The need for additional staffing of direct
23 care registered nurses, licensed vocational or
24 practical nurses, licensed psychiatric techni-
25 cians, certified nursing or patient care assist-

1 ants, or other licensed or unlicensed ancillary
2 staff above the minimum registered nurse-to-pa-
3 tient ratios shall be based on the assessment of
4 the individual patient's nursing care require-
5 ment, the individual patient's nursing care plan,
6 and acuity level.

7 “(4) RESTRICTIONS.—

8 “(A) PROHIBITION AGAINST AVERAGING.—
9 A hospital shall not average the number of pa-
10 tients and the total number of direct care reg-
11 istered nurses assigned to patients in a hospital
12 unit during any 1 shift or over any period of
13 time for purposes of meeting the requirements
14 under this subsection.

15 “(B) PROHIBITION AGAINST IMPOSITION
16 OF MANDATORY OVERTIME REQUIREMENTS.—A
17 hospital shall not impose mandatory overtime
18 requirements to meet the hospital unit direct
19 care registered nurse-to-patient ratios required
20 under this subsection.

21 “(C) RELIEF DURING ROUTINE AB-
22 SENCES.—A hospital shall ensure that only a
23 direct care registered nurse who has dem-
24 onstrated current competence to the hospital in
25 providing care on a particular unit and has also

1 received orientation to that hospital's unit suffi-
2 cient to provide competent care to patients in
3 that unit may relieve another direct care reg-
4 istered nurse during breaks, meals, and other
5 routine, expected absences from a hospital unit.

6 “(D) APPLICATION OF DIRECT CARE REG-
7 ISTERED NURSE-TO-PATIENT RATIOS IN PA-
8 TIENT-ACUITY ADJUSTABLE UNITS.—Patients
9 shall be cared for only on units or patient care
10 areas where the direct care registered nurse-to-
11 patient ratios meet the level of intensity, type
12 of care, and the individual requirements and
13 needs of each patient. Notwithstanding para-
14 graph (2), hospitals that provide patient care in
15 units or patient care areas that are acuity
16 adaptable or acuity adjustable shall apply the
17 direct care registered nurse-to-patient ratio re-
18 quired in this section for the highest patient
19 acuity level or level of care in that unit or pa-
20 tient care area, and shall comply with all other
21 requirements of this section.

22 “(E) USE OF VIDEO MONITORS.—A hos-
23 pital shall not employ video monitors or any
24 form of electronic visualization of a patient as
25 a substitute for the direct observation required

1 for patient assessment by the direct care reg-
2 istered nurse or required for patient protection.
3 Video monitors or any form of electronic visual-
4 ization of a patient shall not be included in the
5 calculation of the direct care registered nurse-
6 to-patient ratio required in this subsection and
7 shall not replace the requirement of paragraph
8 (3)(D) that each patient shall be assigned to a
9 direct care registered nurse who shall directly
10 provide the assessment, planning, supervision,
11 implementation, and evaluation of the nursing
12 care provided to the patient at least every shift
13 and have the responsibility for the provision of
14 care to a particular patient within his or her
15 scope of practice.

16 “(F) USE OF OTHER TECHNOLOGY.—A
17 hospital shall not employ technology that sub-
18 stitutes for the assigned registered nurse’s pro-
19 fessional judgment in assessment, planning, im-
20 plementation, and evaluation of care.

21 “(5) ADJUSTMENT OF RATIOS.—

22 “(A) IN GENERAL.—If necessary to protect
23 patient safety, the Secretary may prescribe reg-
24 ulations that—

1 “(i) increase minimum direct care reg-
2 istered nurse-to-patient ratios under this
3 subsection to reduce the number of pa-
4 tients that may be assigned to each direct
5 care nurse; or

6 “(ii) add minimum direct care reg-
7 istered nurse-to-patient ratios for units not
8 referred to in paragraphs (1) and (2).

9 “(B) CONSULTATION.—Such regulations
10 shall be prescribed after consultation with af-
11 fected hospitals and registered nurses.

12 “(6) ANCILLARY AND ADDITIONAL STAFFING.—

13 “(A) IN GENERAL.—The Secretary may
14 prescribe regulations requiring additional staff-
15 ing of direct care registered nurses, licensed vo-
16 cational or practice nurses, licensed psychiatric
17 technicians, certified nursing or patient care as-
18 sistants, or other licensed or unlicensed ancil-
19 lary staff above the minimum registered nurse-
20 to-patient ratios that is based on the assess-
21 ment of the individual patient’s nursing care
22 needs, the individual patient’s nursing care
23 plan, and acuity level.

24 “(B) CONSULTATION.—Such regulations
25 shall be prescribed after consultation with af-

1 fected hospitals, registered nurses, and ancillary
2 staff.

3 “(7) RELATIONSHIP TO STATE-IMPOSED RA-
4 TIOS.—Nothing in this title shall preempt State
5 standards that the Secretary determines to be as
6 stringent as Federal requirements for a staffing plan
7 established under this title. Minimum direct care
8 registered nurse-to-patient ratios established under
9 this subsection shall not preempt State requirements
10 that the Secretary determines are as stringent as to
11 Federal requirements for direct care registered
12 nurse-to-patient ratios established under this title.

13 “(8) EXEMPTION IN EMERGENCIES.—The re-
14 quirements established under this subsection shall
15 not apply during a state of emergency if a hospital
16 is requested or expected to provide an exceptional
17 level of emergency or other medical services. If a
18 hospital seeks to apply the exemption under this
19 paragraph in response to a complaint filed against
20 the hospital for a violation of the provisions of this
21 title, the hospital must demonstrate that prompt and
22 diligent efforts were made to maintain required
23 staffing levels. The Secretary shall issue guidance to
24 hospitals that describes situations that constitute a
25 state of emergency for purposes of the exemption

1 under this paragraph and shall establish necessary
2 penalties for violations of this paragraph consistent
3 with section 3406.

4 “(c) DEVELOPMENT AND REEVALUATION OF STAFF-
5 ING PLAN.—

6 “(1) CONSIDERATIONS IN DEVELOPMENT OF
7 PLAN.—In developing the staffing plan, a hospital
8 shall provide for direct care registered nurse-to-pa-
9 tient ratios above the minimum direct care reg-
10 istered nurse-to-patient ratios required under sub-
11 section (b) if appropriate based upon consideration
12 of, at a minimum, the following factors:

13 “(A) The number of patients on a par-
14 ticular unit on a shift-by-shift basis.

15 “(B) The acuity level and nursing care
16 plan of patients on a particular unit on a shift-
17 by-shift basis.

18 “(C) The anticipated admissions, dis-
19 charges, and transfers of patients during each
20 shift that impacts direct patient care.

21 “(D) Specialized experience required of di-
22 rect care registered nurses on a particular unit.

23 “(E) Staffing levels and services provided
24 by licensed vocational or practical nurses, li-
25 censed psychiatric technicians, certified nurse

1 assistants, or other ancillary staff in meeting
2 direct patient care needs not required by a di-
3 rect care registered nurse.

4 “(F) The level of familiarity with hospital
5 practices, policies, and procedures by temporary
6 agency direct care registered nurses used dur-
7 ing a shift.

8 “(G) Obstacles to efficiency in the delivery
9 of patient care presented by physical layout.

10 “(2) DOCUMENTATION OF STAFFING.—A hos-
11 pital shall specify the system used to document ac-
12 tual staffing in each unit for each shift.

13 “(3) ANNUAL REEVALUATION OF PLAN.—

14 “(A) IN GENERAL.—A hospital shall annu-
15 ally evaluate its staffing plan in each unit in re-
16 lation to actual patient care requirements.

17 “(B) UPDATE.—A hospital shall update its
18 staffing plan to the extent appropriate based on
19 such evaluation.

20 “(4) TRANSPARENCY.—

21 “(A) IN GENERAL.—Any staffing plan or
22 method used to create and evaluate acuity-level
23 and adopted by a hospital under this section
24 shall be transparent in all respects, including
25 disclosure of detailed documentation of the

1 methodology used to determine nursing staff-
2 ing, identifying each factor, assumption, and
3 value used in applying such methodology.

4 “(B) PUBLIC AVAILABILITY.—The Sec-
5 retary shall establish procedures to provide that
6 the documentation submitted under subsection
7 (d) is available for public inspection in its en-
8 tirety.

9 “(5) REGISTERED NURSE PARTICIPATION.—A
10 staffing plan of a hospital—

11 “(A) shall be developed and subsequent re-
12 evaluations shall be conducted under this sub-
13 section on the basis of input from direct care
14 registered nurses at the hospital from each unit
15 or patient care area; and

16 “(B) where such nurses are represented
17 through collective bargaining, shall require bar-
18 gaining with the applicable recognized or cer-
19 tified collective bargaining representative of
20 such nurses.

21 Nothing in this title shall be construed to permit
22 conduct prohibited under the National Labor Rela-
23 tions Act or chapter 71 of title 5, United States
24 Code.

1 “(6) STAFFING COMMITTEES.—If a hospital
2 maintains a staffing committee, then the committee
3 shall include at least one registered nurse from each
4 hospital unit and shall be composed of at least 50
5 percent direct care registered nurses. The staffing
6 committee shall include meaningful representation of
7 other direct care nonmanagement staff. Direct care
8 registered nurses who serve on the committee shall
9 be selected by other direct care registered nurses
10 from their unit. Other direct care nonmanagement
11 staff shall be selected by other direct care non-
12 management staff. Participation on staffing commit-
13 tees shall be considered a part of the employee’s reg-
14 ularly scheduled workweek.

15 “(d) SUBMISSION OF PLAN TO SECRETARY.—A hos-
16 pital shall submit to the Secretary its staffing plan and
17 any annual updates under subsection (c)(3)(B). A feder-
18 ally operated hospital may submit its staffing plan
19 through the department or agency operating the hospital.

20 **“SEC. 3402. POSTING, RECORDS, AND AUDITS.**

21 “(a) POSTING REQUIREMENTS.—In each unit, a hos-
22 pital shall post a uniform notice in a form specified by
23 the Secretary in regulation that—

24 “(1) explains requirements imposed under sec-
25 tion 3401;

1 “(2) includes actual direct care registered
2 nurse-to-patient ratios during each shift;

3 “(3) includes the actual number and titles of di-
4 rect care registered nurses assigned during each
5 shift; and

6 “(4) is visible, conspicuous, and accessible to
7 staff, patients, and the public.

8 “(b) RECORDS.—

9 “(1) MAINTENANCE OF RECORDS.—Each hos-
10 pital shall maintain accurate records of actual direct
11 care registered nurse-to-patient ratios in each unit
12 for each shift for no less than 3 years. Such records
13 shall include—

14 “(A) the number of patients in each unit;

15 “(B) the identity and duty hours of—

16 “(i) each direct care registered nurse
17 assigned to each patient in each unit in
18 each shift; and

19 “(ii) ancillary staff who are under the
20 coordination of the direct care registered
21 nurse;

22 “(C) certification that each nurse received
23 rest and meal breaks and the identity and duty
24 hours of each direct care registered nurse who
25 provided such relief; and

1 “(D) a copy of each notice posted under
2 subsection (a).

3 “(2) AVAILABILITY OF RECORDS.—Each hos-
4 pital shall make its records maintained under para-
5 graph (1) available to—

6 “(A) the Secretary;

7 “(B) registered nurses and their collective
8 bargaining representatives (if any); and

9 “(C) the public under regulations estab-
10 lished by the Secretary, or in the case of a fed-
11 erally operated hospital, under section 552 of
12 title 5, United States Code (commonly known
13 as the Freedom of Information Act).

14 “(c) AUDITS.—The Secretary shall conduct periodic
15 audits to ensure—

16 “(1) implementation of the staffing plan in ac-
17 cordance with this title; and

18 “(2) accuracy in records maintained under this
19 section.

20 **“SEC. 3403. MINIMUM DIRECT CARE LICENSED PRACTICAL**
21 **NURSE STAFFING REQUIREMENTS.**

22 “(a) ESTABLISHMENT.—A hospital’s staffing plan
23 shall comply with minimum direct care licensed practical
24 nurse staffing requirements that the Secretary establishes
25 for units in hospitals. Such staffing requirements shall be

1 established not later than 18 months after the date of the
2 enactment of this title, and shall be based on the study
3 conducted under subsection (b).

4 “(b) STUDY.—Not later than 1 year after the date
5 of the enactment of this title, the Secretary, acting
6 through the Director of the Agency for Healthcare Re-
7 search and Quality, shall complete a study of licensed
8 practical nurse staffing and its effects on patient care in
9 hospitals. The Director may contract with a qualified enti-
10 ty or organization to carry out such study under this para-
11 graph. The Director shall consult with licensed practical
12 nurses and organizations representing licensed practical
13 nurses regarding the design and conduct of the study.

14 “(c) APPLICATION OF REGISTERED NURSE PROVI-
15 SIONS TO LICENSED PRACTICAL NURSE STAFFING RE-
16 QUIREMENTS.—Paragraphs (2), (4)(A), (4)(B), (4)(C),
17 and (6) of section 3401(b), paragraphs (1), (2), (3), and
18 (4) of section 3401(c), and section 3402 shall apply to
19 the establishment and application of direct care licensed
20 practical nurse staffing requirements under this section
21 pursuant to the additional staffing requirements under
22 subsection (b)(3)(G) of section 3401 and in the same man-
23 ner that they apply to the establishment and application
24 of direct care registered nurse-to-patient ratios under sec-
25 tions 3401 and 3402.

1 “(d) EFFECTIVE DATE.—The requirements of this
2 section shall take effect as soon as practicable, as deter-
3 mined by the Secretary, but not later than—

4 “(1) 2 years after the date of the enactment of
5 this title; and

6 “(2) in the case of a hospital in a rural area
7 (as defined in section 1886(d)(2)(D) of the Social
8 Security Act), 4 years after the date of the enact-
9 ment of this title.

10 “(e) STUDY.—Not later than 1 year after the date
11 of the enactment of this title, the Secretary, acting
12 through the Director of the Agency for Healthcare Re-
13 search and Quality shall complete a study of registered
14 and practical nurse staffing requirements in clinics and
15 other outpatient settings, and its effects on patient care
16 in outpatient settings. The Director may contract with a
17 qualified entity or organization to carry out such study
18 under this subsection. The Director shall consult with reg-
19 istered nurses and licensed practice nurses working in out-
20 patient settings, including professional nursing associa-
21 tions and labor organizations representing both registered
22 and practice nurses working in outpatient settings regard-
23 ing the design and conduct of the study.

1 **“SEC. 3404. WHISTLEBLOWER AND PATIENT PROTECTIONS.**

2 “(a) PROFESSIONAL OBLIGATION AND RIGHTS.—All
3 nurses have a duty and right to act based on their profes-
4 sional judgment in accordance with State nursing laws
5 and regulations of the State in which the direct nursing
6 care is being performed and to provide care in the exclu-
7 sive interests of the patients and to act as the patient’s
8 advocate.

9 “(b) ACCEPTANCE OF PATIENT CARE ASSIGN-
10 MENTS.—The nurse is responsible for providing com-
11 petent, safe, therapeutic, and effective nursing care to as-
12 signed patients. Before accepting a patient assignment, a
13 nurse shall—

14 “(1) have the necessary professional knowledge,
15 judgment, skills, and ability to provide the required
16 care;

17 “(2) determine using professional judgment in
18 accordance with State nursing laws and regulations
19 of the State in which the direct nursing care is being
20 performed whether the nurse is competent to per-
21 form the nursing care required; and

22 “(3) determine whether acceptance of a patient
23 assignment would expose the patient or nurse to risk
24 of harm.

25 “(c) OBJECTION TO OR REFUSAL OF ASSIGNMENT.—
26 A nurse may object to, or refuse to participate in, any

1 activity, policy, practice, assignment, or task if in good
2 faith—

3 “(1) the nurse reasonably believes it to be in
4 violation of section 3401 or 3403; or

5 “(2) the nurse is not prepared by education,
6 training, or experience to fulfill the assignment with-
7 out compromising the safety of any patient or jeop-
8 ardizing the license of the nurse.

9 “(d) RETALIATION FOR OBJECTION TO OR REFUSAL
10 OF ASSIGNMENT BARRED.—

11 “(1) NO DISCHARGE, DISCRIMINATION, OR RE-
12 TALIACTION.—No hospital shall discharge, retaliate,
13 discriminate, or otherwise take adverse action in any
14 manner with respect to any aspect of a nurse’s em-
15 ployment (as defined in section 3407), including dis-
16 charge, promotion, compensation, or terms, condi-
17 tions, or privileges of employment, based on the
18 nurse’s refusal of a work assignment under sub-
19 section (c).

20 “(2) NO FILING OF COMPLAINT.—No hospital
21 shall file a complaint or a report against a nurse
22 with a State professional disciplinary agency because
23 of the nurse’s refusal of a work assignment under
24 subsection (c).

1 “(e) CAUSE OF ACTION.—Any nurse, collective bar-
2 gaining representative, or legal representative of any nurse
3 who has been discharged, discriminated against, or retali-
4 ated against in violation of subsection (d)(1) or against
5 whom a complaint or report has been filed in violation of
6 subsection (d)(2) may (without regard to whether a com-
7 plaint has been filed under subsection (f) of this section
8 or subsection (b) of section 3406) bring a cause of action
9 in a United States district court. A nurse who prevails
10 on the cause of action shall be entitled to one or more
11 of the following:

12 “(1) Reinstatement.

13 “(2) Reimbursement of lost wages, compensa-
14 tion, and benefits.

15 “(3) Attorneys’ fees.

16 “(4) Court costs.

17 “(5) Other damages.

18 “(f) COMPLAINT TO SECRETARY.—A nurse, patient,
19 collective bargaining representative, or other individual
20 may file a complaint with the Secretary against a hospital
21 that violates the provisions of this title. For any complaint
22 filed, the Secretary shall—

23 “(1) receive and investigate the complaint;

24 “(2) determine whether a violation of this title
25 as alleged in the complaint has occurred; and

1 “(3) if such a violation has occurred, issue an
2 order that the complaining nurse or individual shall
3 not suffer any discharge, retaliation, discrimination,
4 or other adverse action prohibited by subsection (d)
5 or subsection (h).

6 “(g) TOLL-FREE TELEPHONE NUMBER.—

7 “(1) IN GENERAL.—The Secretary shall provide
8 for the establishment of a toll-free telephone hotline
9 to provide information regarding the requirements
10 under sections 3401 through 3403 and to receive re-
11 ports of violations of such section.

12 “(2) NOTICE TO PATIENTS.—A hospital shall
13 provide each patient admitted to the hospital for in-
14 patient care with the hotline described in paragraph
15 (1), and shall give notice to each patient that such
16 hotline may be used to report inadequate staffing or
17 care.

18 “(h) PROTECTION FOR REPORTING.—

19 “(1) PROHIBITION ON RETALIATION OR DIS-
20 CRIMINATION.—A hospital shall not discriminate or
21 retaliate in any manner against any patient, em-
22 ployee, or contract employee of the hospital, or any
23 other individual, on the basis that such individual, in
24 good faith, individually or in conjunction with an-
25 other person or persons, has presented a grievance

1 or complaint, or has initiated or cooperated in any
2 investigation or proceeding of any governmental en-
3 tity, regulatory agency, or private accreditation
4 body, made a civil claim or demand, or filed an ac-
5 tion relating to the care, services, or conditions of
6 the hospital or of any affiliated or related facilities.

7 “(2) GOOD FAITH DEFINED.—For purposes of
8 this subsection, an individual shall be deemed to be
9 acting in good faith if the individual reasonably be-
10 lieves—

11 “(A) the information reported or disclosed
12 is true; and

13 “(B) a violation of this title has occurred
14 or may occur.

15 “(i) PROHIBITION ON INTERFERENCE WITH
16 RIGHTS.—

17 “(1) EXERCISE OF RIGHTS.—It shall be unlaw-
18 ful for any hospital to—

19 “(A) interfere with, restrain, or deny the
20 exercise, or attempt to exercise, by any person
21 of any right provided or protected under this
22 title; or

23 “(B) coerce or intimidate any person re-
24 garding the exercise or attempt to exercise such
25 right.

1 “(2) OPPOSITION TO UNLAWFUL POLICIES OR
2 PRACTICES.—It shall be unlawful for any hospital to
3 discriminate or retaliate against any person for op-
4 posing any hospital policy, practice, or actions which
5 are alleged to violate, breach, or fail to comply with
6 any provision of this title.

7 “(3) PROHIBITION ON INTERFERENCE WITH
8 PROTECTED COMMUNICATIONS.—A hospital (or an
9 individual representing a hospital) shall not make,
10 adopt, or enforce any rule, regulation, policy, or
11 practice which in any manner directly or indirectly
12 prohibits, impedes, or discourages a direct care
13 nurse from, or intimidates, coerces, or induces a di-
14 rect care nurse regarding, engaging in free speech
15 activities or disclosing information as provided under
16 this title.

17 “(4) PROHIBITION ON INTERFERENCE WITH
18 COLLECTIVE ACTION.—A hospital (or an individual
19 representing a hospital) shall not in any way inter-
20 fere with the rights of nurses to organize, bargain
21 collectively, and engage in concerted activity under
22 section 7 of the National Labor Relations Act (29
23 U.S.C. 157).

1 “(j) NOTICE.—A hospital shall post in an appropriate
2 location in each unit a conspicuous notice in a form speci-
3 fied by the Secretary that—

4 “(1) explains the rights of nurses, patients, and
5 other individuals under this section;

6 “(2) includes a statement that a nurse, patient,
7 or other individual may file a complaint with the
8 Secretary against a hospital that violates the provi-
9 sions of this title; and

10 “(3) provides instructions on how to file such a
11 complaint.

12 “(k) EFFECTIVE DATE.—

13 “(1) REFUSAL; RETALIATION; CAUSE OF AC-
14 TION.—

15 “(A) IN GENERAL.—Subsections (c)
16 through (e) shall apply to objections and refus-
17 als occurring on or after the effective date of
18 the provision of this title to which the objection
19 or refusal relates.

20 “(B) EXCEPTION.—Subsection (c)(2) shall
21 not apply to objections or refusals in any hos-
22 pital before the requirements of section 3401(a)
23 or 3403(a), as applicable, apply to that hos-
24 pital.

1 “(2) PROTECTIONS FOR REPORTING.—Sub-
 2 section (h)(1) shall apply to actions occurring on or
 3 after the effective date of the provision to which the
 4 violation relates, except that such subsection shall
 5 apply to initiation, cooperation, or participation in
 6 an investigation or proceeding on or after the date
 7 of enactment of this title.

8 “(3) NOTICE.—Subsection (j) shall take effect
 9 18 months after the date of enactment of this title.

10 **“SEC. 3405. ENFORCEMENT.**

11 “(a) IN GENERAL.—The Secretary shall enforce the
 12 requirements and prohibitions of this title in accordance
 13 with this section.

14 “(b) PROCEDURES FOR RECEIVING AND INVES-
 15 TIGATING COMPLAINTS.—The Secretary shall establish
 16 procedures under which—

17 “(1) any person may file a complaint alleging
 18 that a hospital has violated a requirement or a pro-
 19 hibition of this title; and

20 “(2) such complaints shall be investigated by
 21 the Secretary.

22 “(c) REMEDIES.—If the Secretary determines that a
 23 hospital has violated a requirement of this title, the Sec-
 24 retary—

1 “(1) shall require the facility to establish a cor-
 2 rective action plan to prevent the recurrence of such
 3 violation; and

4 “(2) may impose civil money penalties, as de-
 5 scribed in subsection (d).

6 “(d) CIVIL PENALTIES.—

7 “(1) IN GENERAL.—In addition to any other
 8 penalties prescribed by law, the Secretary may im-
 9 pose civil penalties as follows:

10 “(A) HOSPITAL LIABILITY.—The Secretary
 11 may impose on a hospital found to be in viola-
 12 tion of this title a civil money penalty of—

13 “(i) not more than \$25,000 for the
 14 first knowing violation of this title by such
 15 hospital; and

16 “(ii) not more than \$50,000 for any
 17 subsequent knowing violation of this title
 18 by such hospital.

19 “(B) INDIVIDUAL LIABILITY.—The Sec-
 20 retary may impose on an individual who—

21 “(i) is employed by a hospital found
 22 by the Secretary to have violated this title;
 23 and

24 “(ii) knowingly violates this title,

1 a civil money penalty of not more than \$20,000
2 for each such violation by the individual.

3 “(2) PROCEDURES.—The provisions of section
4 1128A of the Social Security Act (other than sub-
5 sections (a) and (b)) shall apply with respect to a
6 civil money penalty or proceeding under this sub-
7 section in the same manner as such provisions apply
8 with respect to a civil money penalty or proceeding
9 under such section 1128A.

10 “(e) PUBLIC NOTICE OF VIOLATIONS.—

11 “(1) INTERNET WEBSITE.—The Secretary shall
12 publish on the internet website of the Department of
13 Health and Human Services the names of hospitals
14 on which a civil money penalty has been imposed
15 under this section, the violation for which such pen-
16 alty was imposed, and such additional information
17 as the Secretary determines appropriate.

18 “(2) CHANGE OF OWNERSHIP.—With respect to
19 a hospital that had a change of ownership, as deter-
20 mined by the Secretary, penalties imposed on the
21 hospital while under previous ownership shall no
22 longer be published by the Secretary pursuant to
23 paragraph (1) after the 1-year period beginning on
24 the date of change of ownership.

1 “(f) USE OF FUNDS.—Funds collected by the Sec-
2 retary pursuant to this section are authorized to be appro-
3 priated to carry out this title.

4 **“SEC. 3406. DEFINITIONS.**

5 “For purposes of this title:

6 “(1) ACUITY LEVEL.—The term ‘acuity level’
7 means the determination, using a hospital acuity
8 measurement tool that has been developed and es-
9 tablished in coordination with direct care registered
10 nurses and made transparent pursuant to section
11 3401(c)(4), of nursing care requirements, based on
12 the assigned direct care registered nurse’s profes-
13 sional judgment of—

14 “(A) the severity and complexity of an in-
15 dividual patient’s illness or injury;

16 “(B) the need for specialized equipment;
17 and

18 “(C) the intensity of nursing interventions
19 required.

20 “(2) COMPETENCE.—The term ‘competence’ or
21 ‘competent’ means the satisfactory application of the
22 duties and responsibilities of a registered nurse in
23 providing nursing care to specific patient popu-
24 lations and for acuity levels for each patient care
25 unit or area pursuant to the State nursing laws and

1 regulations of the State in which the direct nursing
2 care is being performed.

3 “(3) DIRECT CARE LICENSED PRACTICAL
4 NURSE.—The term ‘direct care licensed practical
5 nurse’ means an individual who has been granted a
6 license by at least one State to practice as a licensed
7 practical nurse or a licensed vocational nurse and
8 who provides bedside care for one or more patients.

9 “(4) DIRECT CARE REGISTERED NURSE.—The
10 term ‘direct care registered nurse’ means an indi-
11 vidual who has been granted a license by at least
12 one State to practice as a registered nurse and who
13 provides bedside care for one or more patients.

14 “(5) EMPLOYMENT.—The term ‘employment’
15 includes the provision of services under a contract or
16 other arrangement.

17 “(6) HOSPITAL.—The term ‘hospital’ has the
18 meaning given that term in section 1861(e) of the
19 Social Security Act.

20 “(7) NURSE.—The term ‘nurse’ means any di-
21 rect care registered nurse or direct care licensed
22 practice nurse (as the case may be), regardless of
23 whether or not the nurse is an employee.

24 “(8) NURSING CARE PLAN.—The term ‘nursing
25 care plan’ means a plan developed by the assigned

1 direct care registered nurse (in accordance with
2 nursing law in the State in which the nursing care
3 is performed) that indicates the nursing care to be
4 given to individual patients that—

5 “(A) considers the acuity level of the pa-
6 tient;

7 “(B) is developed in coordination with the
8 patient, the patient’s family, or other represent-
9 atives when appropriate, and staff of other dis-
10 ciplines involved in the care of the patient;

11 “(C) reflects all elements of the nursing
12 process; and

13 “(D) recommends the number and skill
14 mix of additional licensed and unlicensed direct
15 care staff needed to fully implement the nursing
16 care plan.

17 “(9) PROFESSIONAL JUDGMENT.—The term
18 ‘professional judgment’ means, in accordance with
19 State nursing laws and regulations of the State in
20 which the direct nursing care is being performed, the
21 direct care registered nurse’s application of knowl-
22 edge, expertise, and experience in conducting a com-
23 prehensive nursing assessment of each patient and
24 in making independent decisions about patient care
25 including the need for additional staff.

1 “(10) STAFFING PLAN.—The term ‘staffing
2 plan’ means a staffing plan required under section
3 3401.

4 “(11) STATE OF EMERGENCY.—The term ‘state
5 of emergency’—

6 “(A) means a state of emergency that is
7 an unpredictable or unavoidable occurrence at
8 an unscheduled or unpredictable interval, relat-
9 ing to health care delivery and requiring imme-
10 diate medical interventions and care; and

11 “(B) does not include a state of emergency
12 that results from a labor dispute in the health
13 care industry or consistent understaffing.

14 **“SEC. 3407. RULE OF CONSTRUCTION.**

15 “Nothing in this title shall be construed to authorize
16 disclosure of private and confidential patient information,
17 if such disclosure is not authorized or required by other
18 applicable law.”.

19 (b) RECOMMENDATIONS TO CONGRESS.—Not later
20 than 1 year after the date of enactment of this Act, the
21 Secretary of Health and Human Services shall submit to
22 Congress a report containing recommendations for ensur-
23 ing that sufficient numbers of nurses are available to meet
24 the requirements imposed by title XXXIV of the Public
25 Health Service Act, as added by subsection (a).

1 (c) REPORT BY HRSA.—

2 (1) IN GENERAL.—Not later than 2 years after
3 the date of enactment of this Act, the Administrator
4 of the Health Resources and Services Administra-
5 tion, in consultation with the National Health Care
6 Workforce Commission, shall submit to Congress a
7 report regarding the relationship between nurse
8 staffing levels and nurse retention in hospitals.

9 (2) UPDATED REPORT.—Not later than 5 years
10 after the date of enactment of this Act, the Adminis-
11 trator of the Health Resources and Services Admin-
12 istration, in consultation with the National Health
13 Care Workforce Commission, shall submit to Con-
14 gress an update of the report submitted under para-
15 graph (1).

16 (d) ENFORCEMENT OF REQUIREMENTS THROUGH
17 FEDERAL PROGRAMS.—

18 (1) MEDICARE PROGRAM.—Section 1866(a)(1)
19 of the Social Security Act (42 U.S.C. 1395cc(a)(1))
20 is amended—

21 (A) in subparagraph (X), by striking “,
22 and” and inserting a comma;

23 (B) in subparagraph (Y), by striking the
24 period at the end and inserting “, and”; and

1 (C) by inserting after subparagraph (Y)
2 the following new subparagraph:

3 “(Z) in the case of a hospital, to comply
4 with the provisions of title XXXIV of the Public
5 Health Service Act.”.

6 (2) MEDICAID PROGRAM.—Section 1902(a) of
7 the Social Security Act (42 U.S.C. 1396a(a)) is
8 amended—

9 (A) by striking “and” at the end of para-
10 graph (82);

11 (B) by striking the period at the end of
12 paragraph (83) and inserting “; and”; and

13 (C) by inserting after paragraph (83) the
14 following new paragraph:

15 “(84) provide that any hospital that receives a
16 payment under such plan comply with the provisions
17 of title XXXIV of the Public Health Service Act (re-
18 lating to minimum direct care registered nurse staff-
19 ing requirements).”.

20 (e) NURSING HOMES.—No later than one year after
21 enactment of this Act, the Secretary of Health and
22 Human Services shall promulgate a rule for minimum
23 staffing standards for skilled nursing facilities under the
24 Medicare program and for nursing facilities under the

1 Medicaid program that align with the standards set in this
2 section.

3 **SEC. 134. ENHANCEMENTS FOR REDUCED COST-SHARING.**

4 (a) IN GENERAL.—Section 1402 of the Patient Pro-
5 tection and Affordable Care Act (42 U.S.C. 18071) is
6 amended—

7 (1) in subsection (b)(1), by striking “silver”
8 and inserting “gold”;

9 (2) by amending subsection (c)(1)(B) to read as
10 follows:

11 “(B) COORDINATION WITH ACTUARIAL
12 LIMITS.—The Secretary shall ensure the reduc-
13 tion under this paragraph shall not result in the
14 plan’s share of the total allowed costs of bene-
15 fits provided under the plan becoming less
16 than—

17 “(i) 95 percent in the case of an eligi-
18 ble insured described in paragraph (2)(A);

19 “(ii) 90 percent in the case of an eli-
20 gible insured described in paragraph
21 (2)(B); and

22 “(iii) 85 percent in the case of an eli-
23 gible insured described in paragraph
24 (2)(C).”; and

1 (3) by amending subsection (c)(2) to read as
2 follows:

3 “(2) ADDITIONAL REDUCTION.—The Secretary
4 shall establish procedures under which the issuer of
5 a qualified health plan to which this section applies
6 shall further reduce cost-sharing under the plan in
7 a manner sufficient to—

8 “(A) in the case of an eligible insured
9 whose household income is not less than 100
10 percent but not more than 200 percent of the
11 poverty line for a family of the size involved, in-
12 crease the plan’s share of the total allowed
13 costs of benefits provided under the plan to 95
14 percent of such costs;

15 “(B) in the case of an eligible insured
16 whose household income is more than 200 per-
17 cent but not more than 300 percent of the pov-
18 erty line for a family of the size involved, in-
19 crease the plan’s share of the total allowed
20 costs of benefits provided under the plan to 90
21 percent of such costs; and

22 “(C) in the case of an eligible insured
23 whose household income is more than 300 per-
24 cent but not more than 400 percent of the pov-
25 erty line for a family of the size involved, in-

1 crease the plan’s share of the total allowed
 2 costs of benefits provided under the plan to 85
 3 percent of such costs.”.

4 (b) EFFECTIVE DATE.—The amendments made by
 5 this subsection shall apply to plan years beginning after
 6 December 31, 2019.

7 (c) FUNDING.—Section 1402 of the Patient Protec-
 8 tion and Affordable Care Act (42 U.S.C. 18071) is amend-
 9 ed by adding at the end the following new subsection:

10 “(g) FUNDING.—Out of any funds in the Treasury
 11 not otherwise appropriated, there are appropriated to the
 12 Secretary such sums as may be necessary for payments
 13 under this section.”.

14 **SEC. 135. REPEAL OF BONUS PAYMENTS FOR MEDICARE**
 15 **ADVANTAGE PLANS.**

16 Section 1853(o) of the Social Security Act (42 U.S.C.
 17 1395w–23(o)) is repealed.

18 **TITLE II—TAX PROVISIONS**

19 **SEC. 201. SUNSET OF PUBLIC LAW 115–97.**

20 (a) IN GENERAL.—All provisions of, and amend-
 21 ments made by, Public Law 115–97 shall not apply to cal-
 22 endar, taxable, plan, or limitation years beginning after
 23 December 31, 2019.

24 (b) APPLICATION OF CERTAIN LAWS.—The Internal
 25 Revenue Code of 1986 shall be applied and administered

1 to years described in subsection (a) as if the provisions
2 and amendments described in subsection (a) had never
3 been enacted.

4 **SEC. 202. SURTAX.**

5 There is hereby imposed a tax of 5 percent on the
6 adjusted gross income of each taxpayer to the extent such
7 income exceeds \$500,000.

8 **SEC. 203. BASIS OF PROPERTY ACQUIRED FROM A DECE-**
9 **DENT.**

10 (a) IN GENERAL.—Section 1014 of the Internal Rev-
11 enue Code of 1986 is amended by striking “person, be”
12 and all that follows through the period at the end and
13 inserting the following: “person, be the basis in the hands
14 of the decedent.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section to property acquired or passed after the date
17 of enactment of this Act.

18 **SEC. 204. MEDICARE PAYROLL TAX.**

19 (a) IN GENERAL.—Section 3101(b)(2) of the Internal
20 Revenue Code of 1986 is amended by striking “0.9 per-
21 cent” and inserting “4 percent”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to taxable years begin-
24 ning after the date of the enactment of this Act.

1 **SEC. 205. NET INVESTMENT INCOME TAX.**

2 (a) IN GENERAL.—Section 1411(a) of the Internal
3 Revenue Code of 1986 is amended by striking “3.8 per-
4 cent” each place such term appears and inserting “6.9
5 percent”.

6 (b) EFFECTIVE DATE.—The amendments made by
7 this section shall apply with respect to taxable years begin-
8 ning after the date of the enactment of this Act.

9 **SEC. 206. TERMINATION OF DEDUCTION FOR CONTRIBU-**
10 **TIONS TO HEALTH SAVINGS ACCOUNTS.**

11 Section 223(b) of the Internal Revenue Code of 1986
12 is amended by adding at the end the following new para-
13 graph:

14 “(9) TERMINATION OF DEDUCTION.—Notwith-
15 standing any other provision of this subsection, the
16 monthly limitation for any month beginning after
17 December 31, 2023, is zero.”.

18 **SEC. 207. INCREASE IN EXCISE TAX ON SMALL CIGARS AND**
19 **CIGARETTES AND OTHER TOBACCO PROD-**
20 **UCTS.**

21 (a) SMALL CIGARS.—Section 5701(a)(1) of the Inter-
22 nal Revenue Code of 1986 is amended by striking
23 “\$50.33” and inserting “\$100.66”.

24 (b) CIGARETTES.—Section 5701(b) of such Code is
25 amended—

1 (1) by striking “\$50.33” in paragraph (1) and
2 inserting “\$100.66”; and

3 (2) by striking “\$105.69” in paragraph (2) and
4 inserting “\$211.38”.

5 (c) PIPE TOBACCO.—Section 5701(f) of the Internal
6 Revenue Code of 1986 is amended by striking “\$2.8311
7 cents” and inserting “\$50.00”.

8 (d) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of
9 such Code is amended by striking “\$24.78” and inserting
10 “\$49.56”.

11 (e) LARGE CIGARS.—Paragraph (2) of section
12 5701(a) of the Internal Revenue Code of 1986 is amended
13 by striking “52.75 percent” and all that follows through
14 the period and inserting “\$24.78 per pound (and a propor-
15 tionate tax at the like rate on all fractional parts of a
16 pound) but not less than 5.033 cents per cigar.”.

17 (f) SMOKELESS TOBACCO.—

18 (1) IN GENERAL.—Section 5701(e) of the Inter-
19 nal Revenue Code of 1986 is amended—

20 (A) in paragraph (1), by striking “\$1.51”
21 and inserting “\$28.04”;

22 (B) in paragraph (2), by striking “50.33
23 cents” and inserting “\$12.42”; and

24 (C) by adding at the end the following:

1 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
 2 SINGLE-USE UNITS.—On discrete single-use units,
 3 \$107.65 per each 1,000 single-use units.”.

4 (2) DISCRETE SINGLE-USE UNIT.—Section
 5 5702(m) of such Code is amended—

6 (A) in paragraph (1), by striking “or chew-
 7 ing tobacco” and inserting “chewing tobacco,
 8 discrete single-use unit”;

9 (B) in paragraphs (2) and (3), by inserting
 10 “that is not a discrete single-use unit” before
 11 the period in each such paragraph; and

12 (C) by adding at the end the following:

13 “(4) DISCRETE SINGLE-USE UNIT.—The term
 14 ‘discrete single-use unit’ means any product con-
 15 taining tobacco that—

16 “(A) is not intended to be smoked; and

17 “(B) is in the form of a lozenge, tablet,
 18 pill, pouch, dissolvable strip, or other discrete
 19 single-use or single-dose unit”.

20 **SEC. 208. EXCISE TAX ON ALCOHOL.**

21 (a) DISTILLED SPIRITS.—Section 5001(a)(1) of the
 22 Internal Revenue Code of 1986 is amended by striking
 23 “\$13.50” and inserting “\$16.00”.

1 (b) WINE.—(1) Section 5041(b)(1) of the Internal
2 Revenue Code of 1986 is amended by striking “\$1.07 per
3 wine gallon” and inserting “\$16.00 per proof gallon”.

4 (2) Section 5041(b)(2) of the Internal Revenue Code
5 of 1986 is amended by striking “\$1.57 per wine gallon”
6 and inserting “\$16.00 per proof gallon”.

7 (3) Section 5041(b)(3) of the Internal Revenue Code
8 of 1986 is amended by striking “\$3.15 per wine gallon”
9 and inserting “\$16.00 per proof gallon”.

10 (4) Section 5041(b)(4) of the Internal Revenue Code
11 of 1986 is amended by striking “\$3.40 per wine gallon”
12 and inserting “\$16.00 per proof gallon”.

13 (5) Section 5041(b)(5) of the Internal Revenue Code
14 of 1986 is amended by striking “\$3.30 per wine gallon”
15 and inserting “\$16.00 per proof gallon”.

16 (6) Section 5041(b)(3) of the Internal Revenue Code
17 of 1986 is amended by striking “\$22.6 cents per wine gal-
18 lon” and inserting “\$16.00 per proof gallon”.

19 (c) BEER.—Section 5051(B) of the Internal Revenue
20 Code of 1986 is amended by striking “\$18 for per barrel”
21 and inserting “\$16 per proof gallon”.

22 **SEC. 209. TAX ON SUGARED DRINKS.**

23 (a) IN GENERAL.—Subchapter D of chapter 32 of the
24 Internal Revenue Code of 1986 is amended by inserting
25 after part I the following new part:

1 **“PART II—SUGAR-SWEETENED BEVERAGES**

“Sec. 4171. Imposition of tax.

“Sec. 4172. Definitions.

“Sec. 4173. Special rules.

2 **“SEC. 4171. IMPOSITION OF TAX.**

3 “(a) IN GENERAL.—There is hereby imposed a tax
4 on the sale or transfer of any specified sugar-sweetened
5 beverage product by the manufacturer, producer, or im-
6 porter thereof.

7 “(b) RATE OF TAX.—The rate of tax imposed under
8 subsection (a) shall be equal to one cent per 4.2 grams
9 of caloric sweetener contained in such specified sugar-
10 sweetened beverage product.

11 “(c) PERSONS LIABLE FOR TAX.—The manufac-
12 turer, producer, or importer referred to in subsection (a)
13 shall be liable for the tax imposed by such subsection.

14 **“SEC. 4172. DEFINITIONS.**

15 “(a) SPECIFIED SUGAR-SWEETENED BEVERAGE
16 PRODUCT.—For purposes of this part—

17 “(1) IN GENERAL.—For purposes of this part,
18 the term ‘specified sugar-sweetened beverage prod-
19 uct’ means—

20 “(A) any liquid intended for human con-
21 sumption which contains a caloric sweetener,
22 and

23 “(B) any liquid, or solid mixture of ingre-
24 dients, which—

1 “(i) contains a caloric sweetener, and
2 “(ii) is intended for use as an ingre-
3 dient in a liquid described in subparagraph
4 (A).

5 “(2) EXCEPTIONS.—The following shall not be
6 treated as liquids described in paragraph (1)(A):

7 “(A) Any liquid the primary ingredients of
8 which are milk or soy, rice, or similar plant-
9 based milk substitute.

10 “(B) Any liquid composed entirely of one
11 or more of the following:

12 “(i) The original liquid resulting from
13 the pressing of fruit or vegetables.

14 “(ii) The liquid resulting from the re-
15 constitution of fruit or vegetable juice con-
16 centrate.

17 “(iii) The liquid resulting from the
18 restoration of water to dehydrated fruit or
19 vegetable juice.

20 “(C) Infant formula.

21 “(D) Any liquid products manufactured for
22 use as—

23 “(i) an oral nutritional therapy for
24 persons who cannot absorb or metabolize
25 dietary nutrients from food or beverages,

1 “(ii) a source of necessary nutrition
2 used due to a medical condition, or

3 “(iii) an oral electrolyte solution for
4 infants and children formulated to prevent
5 dehydration due to illness.

6 “(E) Any liquid with respect to which tax
7 is imposed under chapter 51 (relating to dis-
8 tilled spirits, wines, and beer) or under section
9 7652 by reason of the tax imposed under chap-
10 ter 51 being imposed on like articles of domes-
11 tic manufacture.

12 “(b) CALORIC SWEETENER.—For purposes of this
13 part, the term ‘caloric sweetener’ means monosaccharides,
14 disaccharides, and high-fructose corn syrup.

15 **“SEC. 4173. SPECIAL RULES.**

16 “(a) SWEETENER TAXED ONLY ONCE.—In the case
17 of any specified sugar-sweetened beverage product which
18 is manufactured or produced by including one or more
19 other specified sugar-sweetened beverage products, no tax
20 shall be imposed under this section on any caloric sweet-
21 ener contained in the resulting specified sugar-sweetened
22 beverage product if tax was previously imposed under this
23 section on such caloric sweetener when contained in the
24 specified sugar-sweetened beverage product so included.

1 “(b) INFLATION ADJUSTMENT.—In the case of any
 2 sale after December 31, 2015, the one cent amount in sec-
 3 tion 4171(b) shall be increased by an amount equal to—

4 “(1) such amount, multiplied by

5 “(2) the cost-of-living adjustment determined
 6 under section 1(f)(3) for the calendar year in which
 7 such sale occurs, determined by substituting ‘cal-
 8 endar year 2014’ for ‘calendar year 1992’ in sub-
 9 paragraph (B) thereof.

10 Any increase determined under this subsection shall be
 11 rounded to the nearest multiple of one-tenth of a cent.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) Section 4221(a) is amended by adding at
 14 the end the following: “Paragraphs (1), (4), (5), and
 15 (6) shall not apply to the tax imposed under section
 16 4171.”.

17 (2) The table of parts for subchapter D of
 18 chapter 32 of such Code is amended by inserting
 19 after the item relating to part I the following new
 20 item:

“PART II—SUGAR-SWEETENED BEVERAGES”.

21 (c) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Except as provided in para-
 23 graph (2), the amendments made by this section
 24 shall take effect on the date of the enactment of this
 25 Act.

1 (2) EXCISE TAX.—The amendments made by
 2 subsections (a) and (b) shall apply to sales after the
 3 date of the enactment of this Act.

4 **SEC. 210. REPEAL OF EXCISE TAX ON HIGH-COST EM-**
 5 **PLOYER-SPONSORED HEALTH COVERAGE.**

6 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
 7 enue Code of 1986 is amended by striking section 4980I.

8 (b) CONFORMING AMENDMENT.—Section 6051 of
 9 such Code is amended—

10 (1) in paragraph (14) of subsection (a), by
 11 striking “section 4980I(d)(1)” and inserting “sub-
 12 section (g)”, and

13 (2) by adding at the end the following:

14 “(g) APPLICABLE EMPLOYER-SPONSORED COV-
 15 ERAGE.—For purposes of subsection (a)(14)—

16 “(1) IN GENERAL.—The term ‘applicable em-
 17 ployer-sponsored coverage’ means, with respect to
 18 any employee, coverage under any group health plan
 19 made available to the employee by an employer
 20 which is excludable from the employee’s gross in-
 21 come under section 106, or would be so excludable
 22 if it were employer-provided coverage (within the
 23 meaning of such section 106).

24 “(2) EXCEPTIONS.—The term ‘applicable em-
 25 ployer-sponsored coverage’ shall not include—

1 “(A) any coverage (whether through insur-
2 ance or otherwise) described in section
3 9832(c)(1) (other than subparagraph (G) there-
4 of) or for long-term care;

5 “(B) any coverage under a separate policy,
6 certificate, or contract of insurance which pro-
7 vides benefits substantially all of which are for
8 treatment of the mouth (including any organ or
9 structure within the mouth) or for treatment of
10 the eye; or

11 “(C) any coverage described in section
12 9832(c)(3) the payment for which is not exclud-
13 able from gross income and for which a deduc-
14 tion under section 162(l) is not allowable.

15 “(3) COVERAGE INCLUDES EMPLOYEE PAID
16 PORTION.—Coverage shall be treated as applicable
17 employer-sponsored coverage without regard to
18 whether the employer or employee pays for the cov-
19 erage.

20 “(4) GOVERNMENTAL PLANS INCLUDED.—Ap-
21 plicable employer-sponsored coverage shall include
22 coverage under any group health plan established
23 and maintained primarily for its civilian employees
24 by the Government of the United States, by the gov-
25 ernment of any State or political subdivision thereof,

1 or by any agency or instrumentality of any such gov-
2 ernment.

3 “(5) COST OF COVERAGE.—

4 “(A) HEALTH FSAS.—In the case of appli-
5 cable employer-sponsored coverage consisting of
6 coverage under a flexible spending arrangement
7 (as defined in section 2205(g)), the cost of the
8 coverage shall be equal to the amount deter-
9 mined under rules similar to the rules of section
10 4980B(f)(4) with respect to any reimbursement
11 under the arrangement reduced by the contribu-
12 tions described in subsection (a)(14)(B).

13 “(B) ARCHER MSAS AND HSAS.—In the
14 case of applicable employer-sponsored coverage
15 consisting of coverage under an arrangement
16 under which the employer makes contributions
17 described in subsection (b) or (d) of section
18 106, the cost of the coverage shall be equal to
19 the amount of employer contributions under the
20 arrangement until the termination of HSAs as
21 described under section 206 of such Act.

22 “(C) ALLOCATION ON A MONTHLY
23 BASIS.—If cost is determined on other than a
24 monthly basis, the cost shall be allocated to

1 months in a taxable period on such basis as the
 2 Secretary may prescribe.”.

3 (c) CLERICAL AMENDMENT.—The table of sections
 4 for chapter 43 of such Code is amended by striking the
 5 item relating to section 4980I.

6 (d) EFFECTIVE DATE.—The amendments made by
 7 this section shall apply to taxable years beginning after
 8 December 31, 2019.

9 **TITLE III—DRUG-RELATED** 10 **PROVISIONS**

11 **SEC. 301. ESTABLISHMENT OF THE PRESCRIPTION DRUG** 12 **AND MEDICAL DEVICE REVIEW BOARD.**

13 There is established in the Department of Health and
 14 Human Services a board to be known as the Prescription
 15 Drug and Medical Device Price Review Board (in this Act
 16 referred to as the “Board”).

17 **SEC. 302. MEMBERSHIP; STAFF.**

18 (a) MEMBERS.—The Board shall be composed of the
 19 members as follows:

20 (1) The Assistant Secretary for Planning and
 21 Evaluation of the Department of Health and Human
 22 Services (or the Assistant Secretary’s designee).

23 (2) The Administrator of the Centers for Medi-
 24 care & Medicaid Services or, beginning with 2022,

1 the Administrator of the Center for Health Care (or
2 the Administrator's designee).

3 (3) The Assistant Director for the Health Serv-
4 ices Division of the Federal Bureau of Prisons (or
5 the Assistant Director's designee).

6 (4) The Secretary of Defense (or the Sec-
7 retary's designee).

8 (5) The Secretary of Veterans Affairs (or the
9 Secretary's designee).

10 (6) The Commissioner of Food and Drugs (or
11 the Commissioner's designee).

12 (7) The Director of the National Institutes of
13 Health (or the Director's designee).

14 (b) CHAIRPERSON.—The Board shall designate 1
15 member of the Board to serve as the chairperson.

16 (c) DIRECTOR AND STAFF.—

17 (1) DIRECTOR.—The Board shall have a direc-
18 tor who shall be appointed by the chairperson of the
19 Board, subject to rules prescribed by the Board.

20 (2) STAFF.—The director may appoint and fix
21 the pay of such additional personnel as the chair-
22 person considers appropriate, subject to rules pre-
23 scribed by the Board.

24 (3) APPLICABILITY OF CERTAIN CIVIL SERVICE
25 LAWS.—The director and staff of the Board shall be

1 appointed subject to the provisions of title 5, United
2 States Code, governing appointments in the competi-
3 tive service, and shall be paid in accordance with the
4 requirements of chapter 51 and subchapter III of
5 chapter 53 of such title relating to classification and
6 General Schedule pay rates; except that an indi-
7 vidual so appointed may not receive pay in excess of
8 the maximum annual rate of basic pay payable for
9 grade GS-15 of the General Schedule.

10 (d) ASSISTANCE FOR THE BOARD.—Subject to sec-
11 tion 306(g), in carrying out this title, the Board—

12 (1) may seek assistance from outside experts in
13 the fields of consumer advocacy, medicine, pharma-
14 cology, pharmacy, and prescription drug reimburse-
15 ment; and

16 (2) shall establish and maintain an advisory
17 group and a stakeholder group for purposes of seek-
18 ing such assistance.

19 (e) INITIAL MEETING.—The Board shall hold its ini-
20 tial meeting not later than 90 days after the date of the
21 enactment of this Act.

22 (f) BANNED INDIVIDUALS.—

23 (1) DRUG COMPANY LOBBYISTS.—No former
24 registered drug manufacturer lobbyist—

1 (A) may be appointed to the position of
2 Director of the Office; or

3 (B) may be employed by the Office during
4 the 6-year period beginning on the date on
5 which the registered lobbyist terminates its reg-
6 istration in accordance with section 4(d) of the
7 Lobbying Disclosure Act of 1995 (2 U.S.C.
8 1603(d)) or the agent terminates its status, as
9 applicable.

10 (2) SENIOR EXECUTIVES OF LAW-BREAKING
11 COMPANIES.—No former senior executive of a cov-
12 ered entity—

13 (A) may be appointed to the position of
14 Director of the Office; or

15 (B) may be employed by the Office during
16 the 6-year period beginning on the later of—

17 (i) the date of the settlement; and

18 (ii) the date on which the enforcement
19 action has concluded.

20 (3) COVERED ENTITY.—The term “covered en-
21 tity” means any entity that is—

22 (A) a drug manufacturer; and

23 (B)(i) operating under Federal settlement,
24 including a Federal consent decree; or

1 (ii) the subject of an enforcement action in
 2 a court of the United States or by an agency.

3 **SEC. 303. PROHIBITION AGAINST EXCESSIVE PRICE.**

4 (a) PROHIBITION.—Beginning on the effective date
 5 of the regulation required by subsection (b), the manufac-
 6 turer of a prescription drug or medical device shall not
 7 charge an excessive price, as determined pursuant to such
 8 regulation, for such drug or device.

9 (b) FORMULA.—The Board shall by regulation pre-
 10 scribe a formula for determining whether the average
 11 manufacturer price of such drug or device over an annual
 12 quarter is an excessive price.

13 (c) DETERMINATION OF EXCESSIVE PRICE.—If the
 14 Board determines, on its own initiative or in response to
 15 a petition submitted under subsection (d), that the manu-
 16 facturer of a prescription drug or medical device charges
 17 an excessive price for such drug or device in violation of
 18 subsection (a)—

19 (1) the Board shall give the manufacturer—

20 (A) notice of such violation; and

21 (B) subject to subsection (d), a period to
 22 correct such violation; and

23 (2) if the manufacturer fails to correct the vio-
 24 lation by the end of such period, the manufacturer
 25 shall be subject to section 304, section

1 1927(c)(2)(E) of the Social Security Act (as added
2 by subsection (c) of section 304), and section 4192
3 of the Internal Revenue Code of 1986, as added by
4 subsection (d) of section 304.

5 (d) PETITIONS.—Any person may petition the Board
6 to make a determination under subsection (c) regarding
7 the pricing of a prescription drug or medical device. Not
8 later than 90 days after the date of receipt of such a peti-
9 tion, the Board shall—

10 (1) make a determination under subsection (c)
11 regarding such pricing; or

12 (2) decline to make such a determination.

13 (e) CONTINUING VIOLATION.—The Board shall not
14 be required to give a manufacturer an opportunity to cor-
15 rect a violation, as described in subsection (c)(1)(B), be-
16 fore the manufacturer becomes subject to the provisions
17 described in subsection (c)(2) for such violation, if—

18 (1) the Board has already provided such an op-
19 portunity to correct to the manufacturer; and

20 (2) the Board finds that the violation of sub-
21 section (a) is a continuation of an earlier violation
22 with respect to which such an opportunity was pro-
23 vided.

24 (f) CONSIDERATIONS.—The formula required by sub-
25 section (a) shall at a minimum take into consideration—

1 (1) the average manufacturer price of the pre-
2 scription drug or medical device over the respective
3 annual quarter or quarters;

4 (2) the average manufacturer price of other
5 prescription drugs or medical devices in the same
6 therapeutic class over the same quarter or quarters;

7 (3) the average price at which the prescription
8 drug or medical device and other prescription drugs
9 and medical devices in the same therapeutic class
10 have been sold by manufacturers in countries other
11 than the United States;

12 (4) the costs associated with producing and
13 marketing the prescription drug or medical device,
14 the value of the drug or device to patients where suf-
15 ficient data is available to determine such value, the
16 total Federal investment in the development of the
17 drug or device, the size of the patient population re-
18 ceiving the drug or device, and other factors deter-
19 minative as to the true cost of production; and

20 (5) whether the price of the prescription drug
21 or medical device increased during any annual quar-
22 ter by a percentage that is more than 2 percent
23 greater than the CPI increase percentage (as defined
24 in section 215(i) of the Social Security Act (42
25 U.S.C. 415)) for the respective annual quarter.

1 (g) VALUE OR COST-EFFECTIVENESS ASSESS-
2 MENTS.—The use of Quality-Adjusted Life Years, Dis-
3 ability-Adjusted Life Years, or other similar mechanisms
4 is prohibited for use in value or cost-effectiveness assess-
5 ments for purposes of this section.

6 **SEC. 304. ENFORCEMENT PROVISIONS.**

7 (a) REDUCED PATENT TERM.—If the Board finds
8 that the manufacturer of a prescription drug or medical
9 device, who is also an owner of a patent for such drug
10 or device, charged an excessive price for such drug or de-
11 vice in violation of section 303(a), the Board may—

12 (1) reduce the term, by not more than 5 years,
13 of any patent issued under title 35, United States
14 Code, relating to such drug or device; or

15 (2) if the term of each patent for such drug or
16 device has expired, reduce the term, by not more
17 than 5 years, of another patent owned by the patent
18 owner relating to a prescription drug or medical de-
19 vice.

20 (b) CIVIL PENALTIES.—If the Board determines
21 under section 303(c) that a manufacturer of a prescription
22 drug or medical device charged an excessive price for a
23 prescription drug or medical device in violation of section
24 303(a), the Board may impose a civil penalty on the man-
25 ufacturer of not more than 10 percent of the manufactur-

1 er's gross sales of the drug or device during the period
 2 beginning on the date on which an excessive price is first
 3 charged and ending on the date on which the manufac-
 4 turer ceases to charge an excessive price.

5 (c) TAX ON EXCESS PRESCRIPTION DRUG AND MED-
 6 ICAL DEVICE PROFITS.—

7 (1) DETERMINATION OF AMOUNT.—If the
 8 Board determines under section 303(a) that a man-
 9 ufacturer, producer, or importer of a prescription
 10 drug or medical device charged an excessive price for
 11 such prescription drug or medical device during a
 12 taxable year, the Board may determine under this
 13 paragraph a reasonable price for such drug or device
 14 for such taxable year.

15 (2) IMPOSITION OF TAX.—

16 (A) IN GENERAL.—The Internal Revenue
 17 Code of 1986 is amended by inserting after sec-
 18 tion 4191 the following new section:

19 **“SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL**
 20 **DEVICE PRICE.**

21 “(a) IN GENERAL.—There is hereby imposed on the
 22 sale of any prescription drug or medical device by the
 23 manufacturer, producer, or importer a tax equal to the
 24 difference between the price at which such drug or device
 25 is so sold and the reasonable price determined by the Pre-

1 scription Drug and Medical Device Price Review Board
 2 under section 303(c)(1) of the Medicare for America Act
 3 for such drug or device for the taxable year for sales after
 4 the determination.

5 “(b) PRESCRIPTION DRUG OR MEDICAL DEVICE.—
 6 For purposes of this section, the term ‘prescription drug
 7 or medical device’ means any prescription drug (as defined
 8 in section 9008 of the Patient Protection and Affordable
 9 Care Act) or device (as defined in section 201(h) of the
 10 Federal Food, Drug, and Cosmetic Act) intended for hu-
 11 mans.”.

12 (B) CLERICAL AMENDMENT.—The table of
 13 parts for chapter 32 of such Code is amended—

14 (i) in the item relating to subchapter
 15 E, by striking “Medical” and inserting
 16 “Drugs and medical”; and

17 (ii) by inserting after the item relating
 18 to section 4191 the following new item:

“Sec. 4192. Excessive prescription drug and medical device price.”.

19 (3) EFFECTIVE DATE.—This subsection and the
 20 amendments made by this subsection shall apply
 21 with respect to sales after December 31, 2019.

22 **SEC. 305. AUTHORITY.**

23 (a) OBTAINING OFFICIAL DATA.—The chairperson of
 24 the Board may secure directly from any Federal agency
 25 information necessary to enable the Board to carry out

1 its duties. Upon request of the chairperson, the head of
2 the agency shall furnish such information to the Board
3 to the extent such information is not prohibited from dis-
4 closure by law.

5 (b) **MAILS.**—The Board may use the United States
6 mails in the same manner and under the same conditions
7 as other Federal agencies.

8 (c) **ADMINISTRATIVE SUPPORT SERVICES.**—Upon the
9 request of the chairperson of the Board, the Administrator
10 of General Services shall provide to the Board, on a reim-
11 bursable basis, the administrative support services nec-
12 essary for the Board to carry out its duties.

13 (d) **CONTRACT AUTHORITY.**—The Board may con-
14 tract with and compensate government and private agen-
15 cies or persons for the purpose of conducting research,
16 surveys, and other services necessary to enable the Board
17 to carry out its duties.

18 (e) **INVESTIGATIONS.**—The Board may make such in-
19 vestigations as it considers necessary to determine whether
20 there is or may be a violation of any regulation promul-
21 gated under this Act and may require or permit any per-
22 son to file with it a statement in writing, under oath or
23 otherwise as the Board shall determine, as to all the facts
24 and circumstances concerning the matter to be inves-
25 tigated.

1 (f) SUBPOENA POWER.—

2 (1) IN GENERAL.—The Board may issue sub-
3 poenas requiring the attendance and testimony of
4 witnesses and the production of any evidence relat-
5 ing to any matter under investigation by the Board.
6 The attendance of witnesses and the production of
7 evidence may be required from any place within the
8 United States at any designated place of hearing
9 within the United States.

10 (2) FAILURE TO OBEY A SUBPOENA.—If a per-
11 son refuses to obey a subpoena issued under para-
12 graph (1), the Board may apply to a United States
13 district court for an order requiring that person to
14 appear before the Board to give testimony, produce
15 evidence, or both, relating to the matter under inves-
16 tigation. The application may be made within the ju-
17 dicial district where the hearing is conducted or
18 where that person is found, resides, or transacts
19 business. Any failure to obey the order of the court
20 may be punished by the court as civil contempt.

21 (3) SERVICE OF SUBPOENAS.—The subpoenas
22 of the Board shall be served in the manner provided
23 for subpoenas issued by a United States district
24 court under the Federal Rules of Civil Procedure for
25 the United States district courts.

1 (4) SERVICE OF PROCESS.—All process of any
2 court to which application is made under paragraph
3 (2) may be served in the judicial district in which
4 the person required to be served resides or may be
5 found.

6 (5) NOTICE.—Upon issuing any subpoena
7 under this subsection, the Board shall give notice of
8 such issuance to the appropriate committees of Con-
9 gress, including the Committee on Appropriations of
10 the House of Representatives and the Committee on
11 Appropriations of the Senate.

12 (g) CONFIDENTIALITY.—Under this title, the Sec-
13 retary shall enforce applicable law concerning a trade se-
14 cret or confidential information subject to section
15 552(b)(4) of title 5, United States Code, or section 1905
16 of title 18.

17 **SEC. 306. REGULATIONS.**

18 (a) IN GENERAL.—Not later than 1 year after the
19 date of the initial meeting held under section 302(e), the
20 Board shall issue final regulations to carry out this Act.

21 (b) NOTICE AND COMMENT REQUIREMENT.—The
22 regulations developed under subsection (a) shall be issued
23 in accordance with the notice and comment procedures es-
24 tablished under section 553 of title 5, United States Code.

1 **SEC. 307. REPORT TO FEDERAL AGENCIES.**

2 Not later than 1 year after the effective date of the
3 regulations under section 306 and annually thereafter, the
4 Board shall submit to each Federal agency that dispenses
5 or makes payments for the dispensing of prescription
6 drugs or medical devices a report containing a list of each
7 prescription drug and medical device for which an exces-
8 sive price was charged during the preceding calendar year,
9 as determined by the Board under section 303. The Sec-
10 retary shall make this report publicly available.

11 **SEC. 308. DEFINITIONS.**

12 In this title:

13 (1) **AFFILIATE.**—The term “affiliate” means,
14 with respect to a manufacturer, any entity that con-
15 trols, is controlled by, or is under common control
16 with such manufacturer.

17 (2) **AVERAGE MANUFACTURER PRICE.**—The
18 term “average manufacturer price” means the aver-
19 age price charged by the manufacturer of a prescrip-
20 tion drug or medical device, as applicable, for sales
21 of the drug or device by the manufacturer in the
22 United States over the respective annual quarter.

23 (3) **MEDICAL DEVICE.**—The term “medical de-
24 vice” means a device (as defined in section 201 of
25 the Federal Food, Drug, and Cosmetic Act (21
26 U.S.C. 321)).

1 (4) PRESCRIPTION DRUG.—The term “prescrip-
 2 tion drug” means a drug (as defined in section 201
 3 of the Federal Food, Drug, and Cosmetic Act (21
 4 U.S.C. 321)) that is subject to section 503(b)(1) of
 5 such Act (21 U.S.C. 353(b)(1)).

6 (5) MANUFACTURER.—The term “manufac-
 7 turer” means the person—

8 (A) that holds the application for a drug
 9 approved under section 505 of the Federal
 10 Food, Drug, and Cosmetic Act or the license
 11 issued under section 351 of the Public Health
 12 Service Act; or

13 (B) who is responsible for setting the price
 14 for the drug.

15 (6) WHOLESALE ACQUISITION COST.—The term
 16 “wholesale acquisition cost” has the meaning given
 17 that term in section 1847A(c)(6)(B) of the Social
 18 Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

19 **SEC. 309. MORATORIUM ON DIRECT-TO-CONSUMER DRUG**
 20 **ADVERTISING.**

21 The Federal Food, Drug, and Cosmetic Act (21
 22 U.S.C. 301 et seq.) is amended—

23 (1) in section 301 (21 U.S.C. 331), by adding
 24 at the end the following:

1 “(eee) The conduct of direct-to-consumer advertising
2 of a drug in violation of section 506J.”; and

3 (2) in chapter V, by inserting after section 506I
4 (21 U.S.C. 356f) the following:

5 **“SEC. 506J. DIRECT-TO-CONSUMER DRUG ADVERTISING.**

6 “(a) PROHIBITIONS.—

7 “(1) FIRST THREE YEARS.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), no person shall conduct direct-to-
10 consumer advertising of a drug for which an
11 application is submitted under section 505(b)
12 before the end of the 3-year period beginning
13 on the date of the approval of such application.

14 “(B) WAIVER.—The Secretary may waive
15 the application of subparagraph (A) to a drug
16 during the third year of the 3-year period de-
17 scribed in such subparagraph if—

18 “(i) the sponsor of the drug submits
19 an application to the Secretary pursuant to
20 subparagraph (C); and

21 “(ii) the Secretary, after considering
22 the application and any accompanying ma-
23 terials, determines that direct-to-consumer
24 advertising of the drug would have an af-
25 firmative value to public health.

1 “(C) APPLICATION FOR WAIVER.—To seek
2 a waiver under subparagraph (B), the sponsor
3 of a drug shall submit an application to the
4 Secretary at such time, in such manner, and
5 containing such information as the Secretary
6 may require.

7 “(2) SUBSEQUENT YEARS.—The Secretary may
8 prohibit direct-to-consumer advertising of a drug
9 during the period beginning at the end of the 3-year
10 period described in paragraph (1)(A) if the Sec-
11 retary determines that the drug has significant ad-
12 verse health effects based on post-approval studies,
13 risk-benefit analyses, adverse event reports, the sci-
14 entific literature, any clinical or observational stud-
15 ies, or any other appropriate resource.

16 “(b) REGULATIONS.—Not later than 1 year after the
17 date of the enactment of this section, the Secretary shall
18 revise the regulations promulgated under this Act gov-
19 erning drug advertisements to the extent necessary to im-
20 plement this section.

21 “(c) RULE OF CONSTRUCTION.—This section shall
22 not be construed to diminish the authority of the Secretary
23 to prohibit or regulate direct-to-consumer advertising of
24 drugs under other provisions of law.”.

1 **SEC. 310. REPORTING ON JUSTIFICATION FOR DRUG PRICE**
2 **INCREASES.**

3 Title III of the Public Health Service Act (42 U.S.C.
4 241 et seq.) is amended by adding at the end the fol-
5 lowing:

6 **“PART W—DRUG PRICE REPORTING; DRUG**
7 **VALUE FUND**

8 **“SEC. 39900. REPORTING ON JUSTIFICATION FOR DRUG**
9 **PRICE INCREASES.**

10 “(a) DEFINITIONS.—In this section:

11 “(1) MANUFACTURER.—The term ‘manufac-
12 turer’ means the person—

13 “(A) that holds the application for a drug
14 approved under section 505 of the Federal
15 Food, Drug, and Cosmetic Act or the license
16 issued under section 351 of the Public Health
17 Service Act; or

18 “(B) who is responsible for setting the
19 price for the drug.

20 “(2) QUALIFYING DRUG.—The term ‘qualifying
21 drug’ means any drug that is approved under sub-
22 section (c) or (j) of section 505 of the Federal Food,
23 Drug, and Cosmetic Act or licensed under subsection
24 (a) or (k) of section 351 of this Act—

25 “(A) that has a wholesale acquisition cost
26 of \$100 or more per month supply or per a

1 course of treatment that lasts less than a
2 month and is—

3 “(i)(I) subject to section 503(b)(1) of
4 the Federal Food, Drug, and Cosmetic
5 Act; or

6 “(II) commonly administered by hos-
7 pitals (as determined by the Secretary);

8 “(ii) not designated as a drug for a
9 rare disease or condition under section 526
10 of the Federal Food, Drug, and Cosmetic
11 Act; and

12 “(iii) not designated by the Secretary
13 as a vaccine; and

14 “(B) for which, during the previous cal-
15 endar year, at least 1 dollar of the total amount
16 of sales were for individuals enrolled under the
17 Medicare program under title XVIII of the So-
18 cial Security Act (42 U.S.C. 1395 et seq.) or
19 under a State Medicaid plan under title XIX of
20 such Act (42 U.S.C. 1396 et seq.) or under a
21 waiver of such plan.

22 “(3) WHOLESALE ACQUISITION COST.—The
23 term ‘wholesale acquisition cost’ has the meaning
24 given that term in section 1847A(c)(6)(B) of the So-
25 cial Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

1 “(b) REPORT.—

2 “(1) REPORT REQUIRED.—The manufacturer of
3 a qualifying drug shall submit a report to the Sec-
4 retary for each price increase of a qualifying drug
5 that will result in an increase in the wholesale acqui-
6 sition cost of that drug that is equal to—

7 “(A) 10 percent or more over a 12-month
8 period; or

9 “(B) 25 percent or more over a 36-month
10 period.

11 “(2) REPORT DEADLINE.—Each report de-
12 scribed in paragraph (1) shall be submitted to the
13 Secretary not later than 30 days prior to the
14 planned effective date of such price increase.

15 “(c) CONTENTS.—A report under subsection (b)
16 shall, at a minimum, include—

17 “(1) with respect to the qualifying drug—

18 “(A) the percentage by which the manufac-
19 turer will raise the wholesale acquisition cost of
20 the drug on the planned effective date of such
21 price increase;

22 “(B) a justification for, and description of,
23 each manufacturer’s price increase that will
24 occur during the 12-month period described in

1 subsection (b)(1)(A) or the 36-month period de-
2 scribed in subsection (b)(1)(B), as applicable;

3 “(C) the identity of the initial developer of
4 the drug;

5 “(D) a description of the history of the
6 manufacturer’s price increases for the drug
7 since the approval of the application for the
8 drug under section 505 of the Federal Food,
9 Drug, and Cosmetic Act or the issuance of the
10 license for the drug under section 351, or since
11 the manufacturer acquired such approved appli-
12 cation or license;

13 “(E) the current list price of the drug;

14 “(F) the total expenditures of the manu-
15 facturer on—

16 “(i) materials and manufacturing for
17 such drug; and

18 “(ii) acquiring patents and licensing
19 for such drug;

20 “(G) the percentage of total expenditures
21 of the manufacturer on research and develop-
22 ment for such drug that was derived from Fed-
23 eral funds;

1 “(H) the total expenditures of the manu-
2 facturer on research and development for such
3 drug that is used for—

4 “(i) basic and preclinical research;

5 “(ii) clinical research;

6 “(iii) new drug development;

7 “(iv) pursuing new or expanded indi-
8 cations for such drug through supple-
9 mental applications under section 505 of
10 the Federal Food, Drug, and Cosmetic Act
11 or section 351 of the Public Health Service
12 Act; and

13 “(v) carrying out postmarket require-
14 ments related to such drug, including those
15 under section 505(o)(3) of the Federal
16 Food, Drug, and Cosmetic Act;

17 “(I) the total revenue and the net profit
18 generated from the qualifying drug for each cal-
19 endar year since the approval of the application
20 for the drug under section 505 of the Federal
21 Food, Drug, and Cosmetic Act or the issuance
22 of the license for the drug under section 351,
23 or since the manufacturer acquired such ap-
24 proved application or license; and

1 “(J) the total costs associated with mar-
2 keting and advertising for the qualifying drug;
3 “(2) with respect to the manufacturer—

4 “(A) the total revenue and the net profit
5 of the manufacturer for each of the 12- and 36-
6 month periods preceding the submission of the
7 report;

8 “(B) all stock-based performance metrics
9 used by the manufacturer to determine execu-
10 tive compensation for each of the 12- and 36-
11 month periods preceding the submission of the
12 report; and

13 “(C) any additional information the manu-
14 facturer chooses to provide related to drug pric-
15 ing decisions, such as total expenditures on—

16 “(i) drug research and development;
17 or

18 “(ii) clinical trials on drugs that failed
19 to receive approval by the Food and Drug
20 Administration; and

21 “(3) such other related information as the Sec-
22 retary considers appropriate.

23 “(d) CIVIL PENALTY.—Any manufacturer of a quali-
24 fying drug that fails to submit a report for the drug as

1 required by this section shall be subject to a civil penalty
2 of \$100,000 for each day on which the violation continues.

3 “(e) PUBLIC POSTING.—

4 “(1) IN GENERAL.—Subject to paragraph (3),
5 not later than 30 days after the submission of a re-
6 port under subsection (b), the Secretary shall post
7 the report on the public website of the Department
8 of Health and Human Services.

9 “(2) FORMAT.—In developing the format of
10 such report for public posting, the Secretary shall
11 consult stakeholders, including beneficiary groups,
12 and shall seek feedback on the content and format
13 from consumer advocates and readability experts to
14 ensure such public reports are user-friendly to the
15 public and are written in plain language that con-
16 sumers can readily understand.

17 “(3) TRADE SECRETS AND CONFIDENTIAL IN-
18 FORMATION.—In carrying out this section, the Sec-
19 retary shall enforce applicable law concerning the
20 protection of confidential commercial information
21 and trade secrets.

22 **“SEC. 39900–1. USE OF CIVIL PENALTY AMOUNTS.**

23 “The Secretary shall, without further appropriation,
24 collect civil penalties under section 39900 and use the
25 funds derived from such civil penalties, in addition to any

1 other amounts available to the Secretary, to carry out ac-
2 tivities described in this part and to improve consumer and
3 provider information about drug value and drug price
4 transparency.

5 **“SEC. 39900–2. ANNUAL REPORT TO CONGRESS.**

6 “(a) IN GENERAL.—Subject to subsection (b), the
7 Secretary shall submit to Congress, and post on the public
8 website of the Department of Health and Human Services
9 in a way that is easy to use and understand, an annual
10 report—

11 “(1) summarizing the information reported pur-
12 suant to section 39900; and

13 “(2) including copies of the reports and sup-
14 porting detailed economic analyses submitted pursu-
15 ant to such section.

16 “(b) TRADE SECRETS AND CONFIDENTIAL INFORMA-
17 TION.—In carrying out this section, the Secretary shall
18 enforce applicable law concerning the protection of con-
19 fidential commercial information and trade secrets.”.

20 **TITLE IV—OUTCOMES AND**
21 **REPORTING**

22 **SEC. 401. SENSE OF CONGRESS.**

23 It is the sense of Congress that Medicare for America
24 will have a significant impact on the health and well-being
25 of the United States population and the social deter-

1 minants of the health of beneficiaries of Medicare for
2 America.

3 **SEC. 402. EVALUATION OF BILL'S OUTCOME.**

4 (a) IN GENERAL.—To assess the impact of this Act
5 on the health of the population, not later than 2 years
6 after the date of the enactment of this Act, the Secretary
7 of Health and Human Services shall allow for analysis of
8 administrative records that have removed all personally
9 identifiable information from the Center for Health Care
10 to existing population surveys conducted by the Federal
11 Government and federally supported surveys.

12 (b) CDC AND NIH.—The Directors of the Centers
13 for Disease Control and Prevention and the National In-
14 stitutes of Health shall solicit a comprehensive, longitu-
15 dinal study to evaluate any differential individual impact
16 on coverage expansion based on—

- 17 (1) race and ethnicity;
18 (2) socioeconomic status; or
19 (3) health status.

20 (c) REPORT.—Ten years after the date of the enact-
21 ment of this Act and every ten years thereafter, the Sec-
22 retary shall submit a report to the House Committee on
23 Energy and Commerce and the Senate Committee on
24 Health, Education, Labor, and Pensions regarding impact
25 of this Act on the health of the United States population

- 1 based on the results of subsection (b) contributions from
- 2 all other relevant agencies.

