

117TH CONGRESS
2D SESSION

S. 4204

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

IN THE SENATE OF THE UNITED STATES

MAY 12, 2022

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

A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare for All Act of 2022”.

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

Sec. 1. Short title; table of contents.

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

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

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

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

TITLE III—PROVIDER PARTICIPATION

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

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

Subtitle B—Control Over Fraud and Abuse

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

TITLE V—QUALITY OF CARE

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

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

Subtitle A—Budgeting

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

Subtitle B—Payments to Providers

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

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

- Sec. 701. Universal Medicare Trust Fund.

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

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

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

TITLE X—TRANSITION TO MEDICARE FOR ALL

Subtitle A—Improvements to Medicare

- Sec. 1001. Protecting Medicare fee-for-service beneficiaries from high out-of-pocket costs.
- Sec. 1002. Reducing Medicare part D annual out-of-pocket threshold and eliminating cost-sharing above that threshold.
- Sec. 1003. Expanding Medicare to cover dental and vision services and hearing aids and examinations under part B.
- Sec. 1004. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.
- Sec. 1005. Guaranteed issue of Medigap policies.

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

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

Subtitle C—Patient Protections During Medicare for All Transition Period

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

TITLE XI—MISCELLANEOUS

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

Sec. 1102. Definitions.

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

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

8 There is hereby established a national health insur-
 9 ance program to provide comprehensive protection against
 10 the costs of health care and health-related services, in ac-
 11 cordance with the standards specified in, or established
 12 under, this Act.

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

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

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

21 (1) may make eligible for benefits for health
 22 care services under this Act other individuals not de-
 23 scribed in subsection (a) and regulate their eligibility

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

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

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

9 Any individual entitled to benefits under this Act may
10 obtain health services from any institution, agency, or in-
11 dividual qualified to participate under this Act.

12 **SEC. 104. NON-DISCRIMINATION.**

13 (a) IN GENERAL.—No person shall, on the basis of
14 race, color, national origin, age, disability, marital status,
15 citizenship status, primary language use, genetic condi-
16 tions, previous or existing medical conditions, religion, or
17 sex, including sex stereotyping, gender identity, sexual ori-
18 entation, and pregnancy and related medical conditions
19 (including termination of pregnancy), be excluded from
20 participation in or be denied the benefits of the program
21 established under this Act (except as expressly authorized
22 by this Act for purposes of enforcing eligibility standards
23 described in section 102), or be subject to any reduction
24 of benefits or other discrimination by any participating
25 provider (as defined in section 301), or any entity con-

1 ducting, administering, or funding a health program or
2 activity, including contracts of insurance, pursuant to this
3 Act.

4 (b) CLAIMS OF DISCRIMINATION.—

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

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

15 (3) DAMAGES.—If the court finds a violation of
16 subsection (a), the court may grant compensatory
17 and punitive damages, declaratory relief, injunctive
18 relief, attorneys' fees and costs, or other relief as ap-
19 propriate.

20 (c) CONTINUED APPLICATION OF LAWS.—Nothing in
21 this title (or an amendment made by this title) shall be
22 construed to invalidate or otherwise limit any of the rights,
23 remedies, procedures, or legal standards available to indi-
24 viduals aggrieved under section 1557 of the Patient Pro-
25 tection and Affordable Care Act (42 U.S.C. 18116), title

1 VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et
 2 seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C.
 3 2000e et seq.), title IX of the Education Amendments of
 4 1972 (20 U.S.C. 1681 et seq.), section 504 of the Reha-
 5 bilitation Act of 1973 (29 U.S.C. 794), or the Age Dis-
 6 crimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing
 7 in this title (or an amendment to this title) shall be con-
 8 strued to supersede State laws that provide additional pro-
 9 tections against discrimination on any basis described in
 10 subsection (a).

11 **SEC. 105. ENROLLMENT.**

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

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

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

22 (3) include a process for the enrollment of indi-
 23 viduals made eligible for health care services under
 24 section 102(b).

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

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

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

14 (b) IMMEDIATE COVERAGE OF CHILDREN.—

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

22 (2) OPTION TO CONTINUE IN OTHER COVERAGE
 23 DURING TRANSITION PERIOD.—Any person who is
 24 eligible to receive benefits as described in paragraph
 25 (1) may opt to maintain any coverage described in

1 section 901, private health insurance coverage, or
2 coverage offered pursuant to subtitle A of title X
3 (including the amendments made by such subtitle)
4 until the date on which benefits are first available
5 under subsection (a).

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

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

10 (1) a private health insurer to sell health insur-
11 ance coverage that duplicates the benefits provided
12 under this Act; or

13 (2) an employer to provide benefits for an em-
14 ployee, former employee, or the dependents of an
15 employee or former employee that duplicate the ben-
16 efits provided under this Act.

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

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

4 **SEC. 201. COMPREHENSIVE BENEFITS.**

5 (a) IN GENERAL.—Subject to the other provisions of
6 this title and titles IV through IX, individuals enrolled for
7 benefits under this Act are entitled to have payment made
8 by the Secretary to an eligible provider for the following
9 items and services if medically necessary or appropriate
10 for the maintenance of health or for the diagnosis, treat-
11 ment, or rehabilitation of a health condition:

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

15 (2) Ambulatory patient services.

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

18 (4) Prescription drugs and medical devices, in-
19 cluding outpatient drugs and devices.

20 (5) Mental health and substance use treatment
21 services, including inpatient care and treatment for
22 co-occurring mental illness and substance use dis-
23 orders.

24 (6) Laboratory and diagnostic services.

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

3 (8) Pediatrics, including early and periodic
4 screening, diagnostic, and treatment services (as de-
5 fined in section 1905(r) of the Social Security Act
6 (42 U.S.C. 1396d(r))).

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

8 (10) Rehabilitative and habilitative services and
9 devices.

10 (11) Emergency services and transportation.

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

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

18 (14) Home and community-based long-term
19 services and supports (to be provided in accordance
20 with the requirements for home and community-
21 based settings under sections 441.530 and 441.710
22 of title 42, Code of Federal Regulations), includ-
23 ing—

1 (A) services described in paragraphs (7),
2 (8), (13), (19), and (24) of section 1905(a) of
3 the Social Security Act (42 U.S.C. 1396d(a));

4 (B) home and community-based services
5 described in subsection (c)(4)(B) of section
6 1915 of the Social Security Act (including ha-
7 bilitation services defined in subsection (c)(5) of
8 such section);

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

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

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

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

1 (c) COMPLEMENTARY AND ALTERNATIVE MEDI-
 2 CINE.—

3 (1) IN GENERAL.—In carrying out subsection
 4 (b), the Secretary shall consult with the persons de-
 5 scribed in paragraph (1) with respect to—

6 (A) identifying specific complementary and
 7 integrative medicine practices that are appro-
 8 priate to include in the benefits package; and

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

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

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

17 (B) the Commissioner of Food and Drugs;

18 (C) institutions of higher education, pri-
 19 vate research institutes, and individual re-
 20 searchers with extensive experience in com-
 21plementary and integrative medicine and the in-
 22tegration of such practices into the delivery of
 23health care;

24 (D) nationally recognized providers of com-
 25plementary and alternative medicine; and

1 (E) such other officials, entities, and indi-
 2 viduals with expertise on complementary and
 3 integrative medicine as the Secretary deter-
 4 mines appropriate.

5 (d) STATES MAY PROVIDE ADDITIONAL BENE-
 6 FITS.—Individual States may provide additional benefits
 7 for the residents of such States, as determined by such
 8 State, and may provide benefits to individuals not eligible
 9 for benefits under this Act at the expense of the State.

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

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

16 (b) EXCEPTIONS.—The Secretary may set a cost-
 17 sharing schedule for prescription drugs—

18 (1) provided that—

19 (A) such schedule is evidence-based, pa-
 20 tient-centered, and encourages the use of ge-
 21 neric drugs;

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

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

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

8 (2) under which the Secretary may—

9 (A) exempt brand-name drugs from consid-
10 eration in determining whether an individual
11 has reached any out-of-pocket limit if a safe
12 and appropriate generic version of such drug is
13 available to such individual; and

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

16 (c) NO BALANCE BILLING.—Notwithstanding con-
17 tracts in accordance with section 303, no provider may
18 impose a charge to an enrolled individual for covered serv-
19 ices for which benefits are provided under this Act.

20 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**

21 (a) IN GENERAL.—Benefits for items and services
22 are not available under this Act unless the services meet
23 the standards developed by the Secretary pursuant to sec-
24 tion 201(a).

1 (b) TREATMENT OF EXPERIMENTAL SERVICES AND
2 DRUGS.—

3 (1) IN GENERAL.—In applying subsection (a),
4 the Secretary shall make national coverage deter-
5 minations with respect to services that are experi-
6 mental in nature. Such determinations shall be con-
7 sistent with the national coverage determination
8 process as defined in section 1869(f)(1)(B) of the
9 Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

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

16 (c) APPLICATION OF PRACTICE GUIDELINES.—

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

24 (2) CERTAIN EXCEPTIONS.—For purposes of
25 this subsection, an item or service not provided in

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

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

18 Title XIX of the Social Security Act (42 U.S.C. 1396
19 et seq.) is amended by inserting the following section after
20 section 1947:

23 “SEC. 1948. (a) IN GENERAL.—For quarters begin-
24 ning on or after the date on which benefits are first avail-
25 able under section 106(a) of the Medicare for All Act of
26 2022, notwithstanding any other provision of this title—

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

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

9 “(A) institutional long-term care services;
 10 or

11 “(B) other services for which benefits are
 12 not available under the Medicare for All Act of
 13 2022 and which are furnished under a State
 14 plan for medical assistance which provided for
 15 medical assistance for such services on Sep-
 16 tember 1, 2021.

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

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

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

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

3 “(4) Inpatient psychiatric hospital services for
4 individuals under age 21 described in section
5 1905(a)(16).

6 “(5) Nursing facility services described in sec-
7 tion 1905(a)(29).

8 “(c) STATE MAINTENANCE OF EFFORT REQUIRE-
9 MENT.—

10 “(1) ELIGIBILITY STANDARDS.—

11 “(A) IN GENERAL.—Beginning on the date
12 described in subsection (a), no payment may be
13 made under section 1903 with respect to med-
14 ical assistance provided under a State plan for
15 medical assistance if the State adopts income,
16 resource, or other standards and methodologies
17 for purposes of determining an individual’s eli-
18 gibility for medical assistance under the State
19 plan that are more restrictive than those ap-
20 plied as of January 1, 2022.

21 “(B) INDEXING OF AMOUNTS OF INCOME
22 AND RESOURCE STANDARDS.—In determining
23 whether a State has adopted income or resource
24 standards that are more restrictive than the
25 standards which applied as of January 1, 2022,

1 the Secretary shall deem the amount of any
2 such standard that was applied as of such date
3 to be increased by the percentage increase in
4 the medical care component of the consumer
5 price index for all urban consumers (U.S. city
6 average) from September of 2021 to September
7 of the fiscal year for which the Secretary is
8 making such determination.

9 “(2) EXPENDITURES.—

10 “(A) IN GENERAL.—For each fiscal year
11 or portion of a fiscal year that occurs during
12 the period that begins on the first day of the
13 first fiscal quarter that begins on or after the
14 date on which benefits are first available under
15 section 106(a) of the Medicare for All Act of
16 2022, as a condition of receiving payments
17 under section 1903(a), a State shall make ex-
18 penditures for medical assistance for services
19 that are institutional long-term care services in
20 an amount that is not less than the expenditure
21 floor determined for the State and fiscal year
22 (or portion of a fiscal year) under subparagraph
23 (B).

24 “(B) EXPENDITURE FLOOR.—

1 “(i) IN GENERAL.—For each fiscal
2 year or portion of a fiscal year described in
3 subparagraph (A), the Secretary shall de-
4 termine for each State an expenditure floor
5 that shall be equal to—

6 “(I) the amount of the State’s
7 expenditures for fiscal year 2021 on
8 medical assistance for institutional
9 long-term care services; increased by

10 “(II) the growth factor deter-
11 mined under subclause (ii).

12 “(ii) GROWTH FACTOR.—For each fis-
13 cal year or portion of a fiscal year de-
14 scribed in subparagraph (A), the Secretary
15 shall, not later than September 1 of the
16 fiscal year preceding such fiscal year or
17 portion of a fiscal year, determine a
18 growth factor for each State that takes
19 into account—

20 “(I) the percentage increase in
21 health care costs in the State;

22 “(II) the total amount expended
23 by the State for the previous fiscal
24 year on medical assistance for institu-
25 tional long-term care services;

1 “(III) the increase, if any, in the
 2 total population of the State from
 3 July of 2021 to July of the fiscal year
 4 preceding the fiscal year involved;

5 “(IV) the increase, if any, in the
 6 population of individuals aged 65 and
 7 older of the State from July of 2021
 8 to July of the fiscal year preceding
 9 the fiscal year involved; and

10 “(V) the decrease, if any, in the
 11 population of the State that requires
 12 medical assistance for institutional
 13 long-term care services that is attrib-
 14 utable to the availability of coverage
 15 for the services described in section
 16 201(a)(13) of the Medicare for All
 17 Act of 2022.

18 “(iii) PRORATION RULE.—Any
 19 amount determined under this subpara-
 20 graph for a portion of a fiscal year shall be
 21 prorated based on the length of such por-
 22 tion of a fiscal year relative to a complete
 23 fiscal year.

24 “(d) NONAPPLICATION OF CERTAIN REQUIRE-
 25 MENTS.—Beginning on the date described in subsection

1 (a), any provision of this title requiring a State plan for
 2 medical assistance to make available medical assistance
 3 for services that are not institutional long-term care serv-
 4 ices or services described in section 901(a)(3)(A)(ii) of the
 5 Medicare for All Act of 2022 shall have no effect.”.

6 **SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID**
 7 **MEDICAID BENEFITS.**

8 Section 1917 of the Social Security Act (42 U.S.C.
 9 1396p) is amended—

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

12 “(a) No lien may be imposed against the property
 13 of any individual prior to his death on account of medical
 14 assistance paid or to be paid on his behalf under the State
 15 plan, except pursuant to the judgment of a court on ac-
 16 count of benefits incorrectly paid on behalf of such indi-
 17 vidual.”; and

18 (2) by amending subsection (b) to read as fol-
 19 lows:

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

23 **SEC. 206. ADDITIONAL STATE STANDARDS.**

24 (a) IN GENERAL.—Nothing in this Act shall prohibit
 25 individual States from setting additional standards, with

1 respect to eligibility, benefits, and minimum provider
 2 standards, consistent with the purposes of this Act, pro-
 3 vided that such standards do not restrict eligibility or re-
 4 duce access to benefits for items and services.

5 (b) RESTRICTIONS ON PROVIDERS.—With respect to
 6 any individuals or entities certified to provide services cov-
 7 ered under section 201(a)(7), a State may not prohibit
 8 an individual or entity from participating in the program
 9 under this Act, for reasons other than the ability of the
 10 individual or entity to provide such services.

11 **TITLE III—PROVIDER** 12 **PARTICIPATION**

13 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS;** 14 **WHISTLEBLOWER PROTECTIONS.**

15 (a) IN GENERAL.—An individual or other entity fur-
 16 nishing any covered item or service under this Act is not
 17 a qualified provider unless the individual or entity—

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

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

22 (3) meets, as applicable, such other qualifica-
 23 tions and conditions with respect to a provider of
 24 services under title XVIII of the Social Security Act

1 as described in section 1866 of the Social Security
2 Act (42 U.S.C. 1395cc).

3 (b) REQUIREMENTS IN PARTICIPATION AGREE-
4 MENT.—

5 (1) IN GENERAL.—A participation agreement
6 described in this subsection between the Secretary
7 and a provider shall provide at least for the fol-
8 lowing:

9 (A) Items and services to eligible persons
10 shall be furnished by the provider without dis-
11 crimination, in accordance with section 104(a).
12 Nothing in this subparagraph shall be con-
13 strued as requiring the provision of a type or
14 class of items or services that are outside the
15 scope of the provider's normal practice.

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

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

24 (i) quality review by designated enti-
25 ties;

1 (ii) making payments under this Act,
2 including the examination of records as
3 may be necessary for the verification of in-
4 formation on which such payments are
5 based;

6 (iii) statistical or other studies re-
7 quired for the implementation of this Act;
8 and

9 (iv) such other purposes as the Sec-
10 retary may specify.

11 (D) In the case of a provider that is not
12 an individual, the provider agrees not to employ
13 or use for the provision of health services any
14 individual or other provider that has had a par-
15 ticipation agreement under this subsection ter-
16 minated for cause. The Secretary may authorize
17 such employment or use on a case-by-case
18 basis.

19 (E) In the case of a provider paid under
20 a fee-for-service basis for items and services
21 furnished under this Act, the provider agrees to
22 submit bills and any required supporting docu-
23 mentation relating to the provision of covered
24 items and services within 30 days after the date
25 of providing such items and services.

1 (F) In the case of an institutional provider
2 paid pursuant to section 611, the provider
3 agrees to submit information and any other re-
4 quired supporting documentation as may be
5 reasonably required by the Secretary within 30
6 days after the date of providing such items and
7 services and in accordance with the uniform re-
8 porting standards established under section
9 401(b)(1), including information on a quarterly
10 basis that—

11 (i) relates to the provision of covered
12 items and services; and

13 (ii) describes items and services fur-
14 nished with respect to specific individuals.

15 (G) In the case of a provider that receives
16 payment for items and services furnished under
17 this Act based on diagnosis-related coding, pro-
18 cedure coding, or other coding system or data,
19 the provider agrees—

20 (i) to disclose to the Secretary any
21 system or index of coding or classifying pa-
22 tient symptoms, diagnoses, clinical inter-
23 ventions, episodes, or procedures that such
24 provider utilizes for global budget negotia-
25 tions under title VI or for meeting any

1 other payment, documentation, or data col-
 2 lection requirements under this Act; and

3 (ii) not to use any such system or
 4 index to establish financial incentives or
 5 disincentives for health care professionals,
 6 or that is proprietary, interferes with the
 7 medical or nursing process, or is designed
 8 to increase the amount or number of pay-
 9 ments.

10 (H) The provider complies with the duty of
 11 provider ethics and reporting requirements de-
 12 scribed in paragraph (2).

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

22 (2) PROVIDER DUTY OF ETHICS.—Each health
 23 care provider, including institutional providers, has a
 24 duty to advocate for and to act in the exclusive in-
 25 terest of each individual under the care of such pro-

1 vider according to the applicable legal standard of
2 care, such that no financial interest or relationship
3 impairs any health care provider's ability to furnish
4 necessary and appropriate care to such individual.
5 To implement the duty established in this para-
6 graph, the Secretary shall—

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

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

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

1 (3) TERMINATION OF PARTICIPATION AGREE-
2 MENT.—

3 (A) IN GENERAL.—Participation agree-
4 ments may be terminated, with appropriate no-
5 tice—

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

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

10 (iii) by a provider.

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

17 (C) PROVIDER PROTECTIONS.—

18 (i) PROHIBITION.—The Secretary may
19 not terminate a participation agreement or
20 in any other way discriminate against, or
21 cause to be discriminated against, any cov-
22 ered provider or authorized representative
23 of the provider, on account of such pro-
24 vider or representative—

1 (I) providing, causing to be pro-
2 vided, or being about to provide or
3 cause to be provided to the provider,
4 the Federal Government, or the attor-
5 ney general of a State information re-
6 lating to any violation of, or any act
7 or omission the provider or represent-
8 ative reasonably believes to be a viola-
9 tion of, any provision of this title (or
10 an amendment made by this title);

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

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

17 (IV) objecting to, or refusing to
18 participate in, any activity, policy,
19 practice, or assigned task that the
20 provider or representative reasonably
21 believes to be in violation of any provi-
22 sion of this Act (including any amend-
23 ment made by this Act), or any order,
24 rule, regulation, standard, or ban

1 under this Act (including any amend-
2 ment made by this Act).

3 (ii) COMPLAINT PROCEDURE.—A pro-
4 vider or representative who believes that he
5 or she has been discriminated against in
6 violation of this section may seek relief in
7 accordance with the procedures, notifica-
8 tions, burdens of proof, remedies, and stat-
9 utes of limitation set forth in section
10 2087(b) of title 15, United States Code.

11 (c) WHISTLEBLOWER PROTECTIONS.—

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

16 (A) notified the Secretary or the employ-
17 ee's employer of any alleged violation of this
18 title, including communications related to car-
19 rying out the employee's job duties;

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

23 (C) testified before or otherwise provided
24 information relevant for Congress or for any

1 Federal or State proceeding regarding any pro-
2 vision (or proposed provision) of this title;

3 (D) commenced, caused to be commenced,
4 or is about to commence or cause to be com-
5 menced a proceeding under this title;

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

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

13 (2) ENFORCEMENT ACTION.—Any employee
14 covered by this section who alleges discrimination by
15 an employer in violation of paragraph (1) may bring
16 an action, subject to the statute of limitations in the
17 anti-retaliation provisions of the False Claims Act
18 and the rules and procedures, legal burdens of proof,
19 and remedies applicable under the employee protec-
20 tions provisions of the Surface Transportation As-
21 sistance Act.

22 (3) APPLICATION.—

23 (A) Nothing in this subsection shall be
24 construed to diminish the rights, privileges, or
25 remedies of any employee under any Federal or

1 State law or regulation, including the rights
2 and remedies against retaliatory action under
3 the False Claims Act (31 U.S.C. 3730(h)), or
4 under any collective bargaining agreement. The
5 rights and remedies in this section may not be
6 waived by any agreement, policy, form, or con-
7 dition of employment.

8 (B) Nothing in this subsection shall be
9 construed to preempt or diminish any other
10 Federal or State law or regulation against dis-
11 crimination, demotion, discharge, suspension,
12 threats, harassment, reprimand, retaliation, or
13 any other manner of discrimination, including
14 the rights and remedies against retaliatory ac-
15 tion under the False Claims Act (31 U.S.C.
16 3730(h)).

17 (4) DEFINITIONS.—In this subsection:

18 (A) EMPLOYER.—The term “employer”
19 means any person engaged in profit or non-
20 profit business or industry, including one or
21 more individuals, partnerships, associations,
22 corporations, trusts, professional membership
23 organization including a certification, discipli-
24 nary, or other professional body, unincorporated
25 organizations, nongovernmental organizations,

1 or trustees, and subject to liability for violating
2 the provisions of this Act.

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

6 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

7 (a) IN GENERAL.—A health care provider is consid-
8 ered a qualified provider to furnish covered items and
9 services under this Act if the provider is licensed or cer-
10 tified to furnish such items and services in the State in
11 which the individual receiving such items and services is
12 located and meets—

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

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

17 (b) FEDERAL PROVIDERS.—Any provider qualified to
18 provide health care items and services at a facility of the
19 Department of Veterans Affairs, the Indian Health Serv-
20 ice, or the uniformed services (as defined in section
21 1072(1) of title 10, United States Code) (with respect to
22 the direct care component of the TRICARE program) is
23 a qualified provider under this section with respect to any
24 individual who qualifies for such items and services under
25 applicable Federal law.

1 (c) MINIMUM PROVIDER STANDARDS.—

2 (1) IN GENERAL.—The Secretary shall estab-
3 lish, evaluate, and update national minimum stand-
4 ards to ensure the quality of items and services pro-
5 vided under this Act and to monitor efforts by
6 States to ensure the quality of items and such serv-
7 ices. A State may also establish additional minimum
8 standards which providers shall meet with respect to
9 services provided in such State.

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

22 (A) adequacy and quality of facilities;

23 (B) training and competence of personnel

24 (including requirements related to the number

25 or type of required continuing education hours);

- 1 (C) comprehensiveness of service;
- 2 (D) continuity of service;
- 3 (E) patient waiting time, access to service,
- 4 and references; and
- 5 (F) performance standards, including orga-
- 6 nization, facilities, structure of services, effi-
- 7 ciency of operation, and outcome in palliation,
- 8 improvement of health, stabilization, cure, or
- 9 rehabilitation.

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

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

18 (a) IN GENERAL.—This section shall apply beginning
 19 on the date on which benefits are first available under sec-
 20 tion 106(a), subject to the provisions of this subsection,
 21 nothing in this Act shall prohibit an institutional or indi-
 22 vidual provider from entering into a private contract with
 23 an enrolled individual for any item or service—

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

1 (2) for which the provider receives—

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

4 (B) receives no amount for such item or
5 service from an organization which receives re-
6 imbursement for such items or service under
7 this Act directly or on a capitated basis.

8 (b) CONTRACT REQUIREMENTS.—

9 (1) IN GENERAL.—Any contract to provide
10 items and services under subsection (a) shall—

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

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

19 (C) contain the items described in para-
20 graph (2).

21 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-
22 TRACT.—Any contract to provide items and services
23 to which subsection (a) applies shall clearly indicate
24 to the individual that by signing such contract the
25 individual—

1 (A) agrees not to submit a claim (or to re-
 2 quest that the provider submit a claim) under
 3 this Act for such items or services even if such
 4 items or services are otherwise covered by this
 5 Act;

6 (B) agrees to be responsible, whether
 7 through insurance offered under section 107(b)
 8 or otherwise, for payment of such items or serv-
 9 ices and understands that no reimbursement
 10 will be provided under this Act for such items
 11 or services;

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

15 (D) if the provider is a nonparticipating
 16 provider, acknowledges that the beneficiary has
 17 the right to have such items or services pro-
 18 vided by other providers for whom payment
 19 would be made under this Act; and

20 (E) acknowledges that the provider is pro-
 21 viding services outside the scope of the program
 22 under this Act.

23 (c) PROVIDER REQUIREMENTS.—

24 (1) IN GENERAL.—Subsection (a) shall not
 25 apply to any contract unless an affidavit described

1 in paragraph (2) is in effect during the period any
2 item or service is to be provided pursuant to the
3 contract.

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

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

8 (B) provide that the practitioner will not
9 submit any claim under this title for any item
10 or service provided to any beneficiary (and will
11 not receive any reimbursement or amount de-
12 scribed in paragraph (1)(B) for any such item
13 or service) during the 1-year period beginning
14 on the date the affidavit is signed; and

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

18 (3) ENFORCEMENT.—If a physician or practi-
19 tioner signing an affidavit described in paragraph
20 (2) knowingly and willfully submits a claim under
21 this title for any item or service provided during the
22 1-year period described in paragraph (2)(B) (or re-
23 ceives any reimbursement or amount described in
24 subsection (a)(2) for any such item or service) with
25 respect to such affidavit—

1 (A) this subsection shall not apply with re-
 2 spect to any items and services provided by the
 3 physician or practitioner pursuant to any con-
 4 tract on and after the date of such submission
 5 and before the end of such period; and

6 (B) no payment shall be made under this
 7 title for any item or service furnished by the
 8 physician or practitioner during the period de-
 9 scribed in clause (i) (and no reimbursement or
 10 payment of any amount described in subsection
 11 (a)(2) shall be made for any such item or serv-
 12 ice).

13 **TITLE IV—ADMINISTRATION**

14 **Subtitle A—General**

15 **Administration Provisions**

16 **SEC. 401. ADMINISTRATION.**

17 (a) GENERAL DUTIES OF THE SECRETARY.—

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

21 (A) eligibility for benefits;

22 (B) enrollment;

23 (C) benefits provided;

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

1 (E) levels of funding;

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

5 (G) a process for appealing or petitioning
6 for a determination of coverage for items and
7 services under this Act;

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

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

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

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

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

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

21 (1) UNIFORM REPORTING STANDARDS.—

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

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

15 (B) REPORTS.—The Secretary shall—

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

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

24 (2) ANNUAL REPORT.—Beginning January 1 of
25 the second year beginning after the effective date of

1 this Act, the Secretary shall annually report to Con-
2 gress on the following:

3 (A) The status of implementation of the
4 Act.

5 (B) Enrollment under this Act.

6 (C) Benefits under this Act.

7 (D) Expenditures and financing under this
8 Act.

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

11 (F) Quality assurance.

12 (G) Health care utilization patterns, in-
13 cluding any changes attributable to the pro-
14 gram.

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

17 (I) Differences in the health status of the
18 populations of the different States, by demo-
19 graphic characteristics, including race, eth-
20 nicity, gender, national origin, primary lan-
21 guage use, age, disability, sex (including gender
22 identity and sexual orientation), geography, or
23 socioeconomic status.

24 (J) Progress on implementing quality and
25 outcome measures under this Act, and long-

1 range plans and goals for achievements in such
2 areas.

3 (K) Plans for improving service to medi-
4 cally underserved populations.

5 (L) Transition problems as a result of im-
6 plementation of this Act.

7 (M) Opportunities for improvements under
8 this Act.

9 (3) STATISTICAL ANALYSES AND OTHER STUD-
10 IES.—The Secretary may, either directly or by con-
11 tract—

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

15 (B) develop and test methods of delivery of
16 items and services as the Secretary may con-
17 sider necessary or promising for the evaluation,
18 or for the improvement, of the operation of this
19 Act; and

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

22 (c) AUDITS.—

23 (1) IN GENERAL.—The Comptroller General of
24 the United States shall conduct an audit of the De-
25 partment of Health and Human Services every fifth

1 fiscal year following the effective date of this Act to
2 determine the effectiveness of the program in car-
3 rying out the duties under subsection (a).

4 (2) REPORTS.—The Comptroller General of the
5 United States shall submit a report to Congress con-
6 cerning the results of each audit conducted under
7 this subsection.

8 **SEC. 402. CONSULTATION.**

9 The Secretary shall consult with Federal agencies,
10 Indian Tribes and urban Indian health organizations, and
11 private entities, such as labor organizations representing
12 health care workers, professional societies, national asso-
13 ciations, nationally recognized associations of health care
14 experts, medical schools and academic health centers, con-
15 sumer groups, and labor business organizations in the for-
16 mulation of guidelines, regulations, policy initiatives, and
17 information gathering to ensure the broadest and most in-
18 formed input in the administration of this Act. Nothing
19 in this Act shall prevent the Secretary from adopting
20 guidelines, consistent with section 203(c), developed by
21 such a private entity if, in the Secretary's judgment, such
22 guidelines are generally accepted as reasonable and pru-
23 dent and consistent with this Act.

1 **SEC. 403. REGIONAL ADMINISTRATION.**

2 (a) REGIONAL MEDICARE FOR ALL OFFICES.—The
3 Secretary shall establish and maintain regional offices for
4 the purpose of carrying out the duties specified in sub-
5 section (c) and promoting adequate access to, and efficient
6 use of, tertiary care facilities, equipment, items, and serv-
7 ices by individuals enrolled under this Act.

8 (b) COORDINATION.—Wherever possible, the Sec-
9 retary shall incorporate the regional offices and the ad-
10 ministrative processes of the Centers for Medicare & Med-
11 icaid Services for the purposes of carrying out subsection
12 (a).

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

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

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

21 (3) one deputy director appointed by the re-
22 gional director to oversee home- and community-
23 based services and supports.

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

25 (1) submit an annual regional health care needs
26 assessment report to the Secretary, after a thorough

1 examination of health needs and consultation with
2 public health officials, clinicians, patients, and pa-
3 tient advocates;

4 (2) recommend any changes in provider reim-
5 bursement or payment for delivery of health items
6 and services determined appropriate by the regional
7 director, subject to the requirements of title VI; and

8 (3) establish a quality assurance mechanism in
9 each such region in order to minimize both under-
10 utilization and over-utilization of health care items
11 and services and to ensure that all providers meet
12 the quality and other standards established pursuant
13 to this Act.

14 **SEC. 404. BENEFICIARY OMBUDSMAN.**

15 (a) IN GENERAL.—The Secretary shall appoint a
16 Beneficiary Ombudsman who shall have expertise and ex-
17 perience in the fields of health care and education of, and
18 assistance to, individuals entitled to benefits under this
19 Act.

20 (b) DUTIES.—The Beneficiary Ombudsman shall—

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

1 (2) provide assistance with respect to com-
2 plaints, grievances, and requests referred to in sub-
3 paragraph (a), including—

4 (A) assistance in collecting relevant infor-
5 mation for such individuals, to seek an appeal
6 of a decision or determination made by a re-
7 gional office or the Secretary; and

8 (B) assistance to such individuals in pre-
9 sented information relating to cost-sharing;
10 and

11 (3) submit annual reports to Congress and the
12 Secretary that describe the activities of the Office
13 and that include such recommendations for improve-
14 ment in the administration of this Act as the Om-
15 budsman determines appropriate. The Ombudsman
16 shall not serve as an advocate for any increases in
17 payments or new coverage of services, but may iden-
18 tify issues and problems in payment or coverage
19 policies.

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

21 In performing functions with respect to health per-
22 sonnel education and training, health research, environ-
23 mental health, disability insurance, vocational rehabilita-
24 tion, the regulation of food and drugs, and all other mat-
25 ters pertaining to health, the Secretary shall direct the ac-

1 tivities of the Department of Health and Human Services
 2 toward contributions to the health of the people com-
 3 plementary to this Act.

4 **Subtitle B—Control Over Fraud** 5 **and Abuse**

6 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL** 7 **FRAUD AND ABUSE UNDER MEDICARE FOR** 8 **ALL PROGRAM.**

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

13 (1) Section 1128 (relating to exclusion of indi-
 14 viduals and entities).

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

16 (3) Section 1128B (criminal penalties).

17 (4) Section 1124 (relating to disclosure of own-
 18 ership and related information).

19 (5) Section 1126 (relating to disclosure of cer-
 20 tain owners).

21 (6) Section 1877 (relating to physician refer-
 22 rals).

1 **TITLE V—QUALITY OF CARE**

2 **SEC. 501. QUALITY STANDARDS.**

3 (a) IN GENERAL.—All standards and quality meas-
4 ures under this Act shall be implemented and evaluated
5 by the Center for Clinical Standards and Quality of the
6 Centers for Medicare and Medicaid Services (referred to
7 in this title as the “Center”) or such other agencies deter-
8 mined appropriate by the Secretary, in coordination with
9 the Agency for Healthcare Research and Quality and other
10 offices of the Department of Health and Human Services.

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

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

20 (2) Review and evaluate each standard of qual-
21 ity, performance measure, and medical review cri-
22 terion developed under part B of title IX of the Pub-
23 lic Health Service Act (42 U.S.C. 299b et seq.). In
24 so reviewing and evaluating, the Center shall deter-
25 mine whether the standard, measure, or criterion is

1 appropriate for use in assessing or reviewing the
2 quality of items and services provided by health care
3 institutions or health care professionals. The use of
4 mechanisms that discriminate against people with
5 disabilities is prohibited for use in any value or cost-
6 effectiveness assessments. The Center shall consider
7 the evidentiary basis for the standard, and the valid-
8 ity, reliability, and feasibility of measuring the
9 standard.

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

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

24 (5) Submission of a report to the Secretary an-
25 nually specifically on findings from outcomes re-

1 search and development of practice guidelines that
 2 may affect the Secretary's determination of coverage
 3 of services under section 401(a)(1)(G).

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

5 (a) EVALUATING DATA COLLECTION AP-
 6 PROACHES.—The Center, in coordination with the Office
 7 of Health Equity established under section 615 and other
 8 agencies in the Department of Health and Human Serv-
 9 ices deemed relevant by the Secretary, shall evaluate ap-
 10 proaches for the collection of data under this Act, to be
 11 performed in conjunction with existing quality reporting
 12 requirements and programs under this Act, that allow for
 13 the ongoing, accurate, and timely collection of data on dis-
 14 parities in health care services and performance on the
 15 basis of race, ethnicity, gender, national origin, primary
 16 language use, age, disability, sex (including gender iden-
 17 tity and sexual orientation), geography, or socioeconomic
 18 status. In conducting such evaluation, the Center shall
 19 consider the following objectives:

20 (1) Protecting patient privacy.

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

24 (3) Improving data on race, ethnicity, national
 25 origin, primary language use, age, disability, sex (in-

cluding gender identity and sexual orientation), geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

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

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

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

1 (2) REPORT ON DATA ANALYSES.—Not later
 2 than 4 years after the submission of the report
 3 under subsection (b)(1), and every 4 years there-
 4 after, the Center shall submit to Congress and the
 5 Secretary a report that includes recommendations
 6 for improving the identification of health care dis-
 7 parities based on the analyses of data collected
 8 under subsection (c).

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

19 **TITLE VI—NATIONAL HEALTH**
 20 **BUDGET; PROVIDER PAY-**
 21 **MENTS; COST CONTAINMENT**
 22 **MEASURES**

23 **Subtitle A—Budgeting**

24 **SEC. 601. NATIONAL HEALTH BUDGET.**

25 (a) NATIONAL HEALTH BUDGET.—

1 (1) IN GENERAL.—By not later than September
 2 1 of each year, beginning with the year prior to the
 3 date on which benefits are first available under sec-
 4 tion 106(a), the Secretary shall establish a national
 5 health budget, which specifies a budget for the total
 6 expenditures to be made for covered health care
 7 items and services under this Act.

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

11 (A) An operating budget.

12 (B) A capital expenditures budget.

13 (C) A special projects budget.

14 (D) Quality assessment activities under
 15 title V.

16 (E) Health professional education expendi-
 17 tures.

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

20 (G) A reserve fund.

21 (H) Prevention and public health activities.

22 (3) ALLOCATION AMONG COMPONENTS.—The
 23 Secretary shall allocate the funds received for pur-
 24 poses of carrying out this Act among the compo-

1 nents described in paragraph (2) in a manner that
2 ensures—

3 (A) that the operating budget allows for
4 every participating provider in the Medicare for
5 All Program to meet the needs of their respec-
6 tive patient populations;

7 (B) that the special projects budget is suf-
8 ficient to meet the health care needs within
9 areas described in paragraph (2)(C) through
10 the construction, renovation, and staffing of
11 health care facilities in a reasonable timeframe;

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

14 (D) that the health professional education
15 expenditure component is sufficient to provide
16 for the amount of health professional education
17 expenditures sufficient to meet the need for cov-
18 ered health care services.

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

1 in such region, administrative expenses in such re-
2 gion, and prevention and public health activities in
3 such region.

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

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

8 (B) payments to individual providers pur-
9 suant to section 612.

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

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

18 (B) major equipment purchases.

19 (7) SPECIAL PROJECTS BUDGET.—The special
20 projects budget described in paragraph (2)(C) shall
21 be used for the purposes of allocating funds for the
22 construction of new facilities, major equipment pur-
23 chases, and staffing in rural or medically under-
24 served areas (as defined in section 330(b)(3) of the
25 Public Health Service Act (42 U.S.C. 254b(b)(3))),

1 including areas designated as health professional
 2 shortage areas (as defined in section 332(a) of the
 3 Public Health Service Act (42 U.S.C. 254e(a))), and
 4 to address health disparities, including racial, ethnic,
 5 national origin, primary language use, age, dis-
 6 ability, sex (including gender identity and sexual ori-
 7 entation), geography, or socioeconomic health dis-
 8 parities.

9 (8) RESERVE FUND.—The reserve fund de-
 10 scribed in paragraph (2)(G) shall be used to respond
 11 to the costs of an epidemic, pandemic, natural dis-
 12 aster, or other such health emergency, or market-
 13 shift adjustments related to patient volume.

14 (b) DEFINITIONS.—In this section:

15 (1) CAPITAL EXPENDITURES.—The term “cap-
 16 ital expenditures” means expenses for the purchase,
 17 lease, construction, or renovation of capital facilities
 18 and for major equipment.

19 (2) HEALTH PROFESSIONAL EDUCATION EX-
 20 PENDITURES.—The term “health professional edu-
 21 cation expenditures” means expenditures in hospitals
 22 and other health care facilities to cover costs associ-
 23 ated with teaching and related research activities, in-
 24 cluding the impact of workforce recruitment, reten-
 25 tion, and diversity on patient outcomes.

1 **SEC. 602. TEMPORARY WORKER ASSISTANCE.**

2 (a) IN GENERAL.—For up to 5 years following the
 3 date on which benefits are first available under section
 4 106(a), at least 1 percent of the national health budget
 5 shall be allocated to programs providing assistance to
 6 workers who perform functions in the administration of
 7 the health insurance system, or related functions within
 8 health care institutions or organizations, who may experi-
 9 ence economic dislocation as a result of the implementa-
 10 tion of this Act.

11 (b) CLARIFICATION.—Assistance described in sub-
 12 paragraph (A) shall include wage replacement, retirement
 13 benefits, job training and placement, preferential hiring,
 14 and education benefits.

15 **Subtitle B—Payments to Providers**

16 **SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS**
 17 **BASED ON GLOBAL BUDGETS.**

18 (a) IN GENERAL.—Not later than the beginning of
 19 each fiscal quarter during which an institutional provider
 20 of care (including hospitals, skilled nursing facilities, and
 21 independent dialysis facilities) is to furnish items and
 22 services under this Act, the Secretary shall pay to such
 23 institutional provider a lump sum in accordance with the
 24 succeeding provisions of this subsection and consistent
 25 with the following:

1 (1) PAYMENT IN FULL.—Such payment shall be
2 considered as payment in full for all operating ex-
3 penses for items and services furnished under this
4 Act, whether inpatient or outpatient, by such pro-
5 vider for such quarter, including outpatient or any
6 other care provided by the institutional provider or
7 provided by any health care provider who provided
8 items and services pursuant to an agreement paid
9 through the global budget as described in paragraph
10 (3).

11 (2) QUARTERLY REVIEW.—The regional direc-
12 tor, on a quarterly basis, shall review whether re-
13 quirements of the institutional provider's participa-
14 tion agreement and negotiated global budget have
15 been performed and shall determine whether adjust-
16 ments to such institutional provider's payment are
17 warranted. This review shall include consideration
18 for additional funding necessary for unanticipated
19 items and services for individuals with complex med-
20 ical needs or market-shift adjustments related to pa-
21 tient volume, and an assessment of any adjustments
22 made to ensure that accuracy and need for adjust-
23 ment was appropriate.

24 (3) AGREEMENTS FOR SALARIED PAYMENTS
25 FOR CERTAIN PROVIDERS.—Certain group practices

1 and other health care providers, as determined by
2 the Secretary, with agreements to provide items and
3 services at a specified institutional provider paid a
4 global budget under this subsection may elect to be
5 paid through such institutional provider's global
6 budget in lieu of payment under section 612. Any—

7 (A) individual health care professional of
8 such group practice or other provider receiving
9 payment through an institutional provider's
10 global budget shall be paid on a salaried basis
11 that is equivalent to salaries or other compensa-
12 tion rates negotiated for individual health care
13 professionals of such institutional provider; and

14 (B) any group practice or other health care
15 provider that receives payment through an in-
16 stitucional provider global budget under this
17 paragraph shall be subject to the same report-
18 ing and disclosure requirements of the institu-
19 tional provider.

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

24 (A) Factors that led to increased costs for
25 the institutional provider that can reasonably be

considered to be unanticipated and out of the control of the institutional provider, such as—

(i) natural disasters;

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

(iii) unexpected facility or equipment repairs or purchases;

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

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

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

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

(b) PAYMENT AMOUNT.—

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

1 vider. Such amount shall be based on factors speci-
2 fied in paragraph (2).

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

6 (A) the historical volume of services pro-
7 vided for each item and services in the previous
8 3-year period;

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

14 (i) such expenditures for other institu-
15 tional providers in the director's jurisdic-
16 tion; and

17 (ii) normative payment rates estab-
18 lished under comparative payment rate
19 systems, including any adjustments, for
20 such items and services;

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

23 (D) wages for employees, including any
24 necessary increases to ensure mandatory min-
25 imum safe registered nurse-to-patient ratios

1 and optimal staffing levels for physicians and
2 other health care workers;

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

5 (F) education and prevention programs;

6 (G) permissible adjustment to the pro-
7 vider's operating budget due to factors such
8 as—

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

11 (ii) efforts to decrease health care dis-
12 parities in rural or medically underserved
13 areas;

14 (iii) a response to emergent epidemic
15 conditions;

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

18 (v) proposed new and innovative pa-
19 tient care programs at the institutional
20 level;

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

1 (I) any other factor determined appro-
2 priate by the Secretary.

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

5 (A) take into account capital expenditures
6 of the provider or any other expenditure not di-
7 rectly associated with the provision of items and
8 services by the provider to an individual;

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

11 (C) exceed the provider's capacity to pro-
12 vide care under this Act; or

13 (D) be used to pay or otherwise com-
14 pensate any board member, executive, or ad-
15 ministrator of the institutional provider who
16 has any interest or relationship prohibited
17 under section 301(b)(2) or disclosed under sec-
18 tion 301.

19 (4) LIMITATION ON COMPENSATION.—Com-
20 pensation costs for any employee or any contractor
21 or any subcontractor employee of an institutional
22 provider receiving global budgets under this section
23 shall meet the compensation cap established in sec-
24 tion 702 of the Bipartisan Budget Act of 2013 (41
25 U.S.C. 4304(a)(16)) and implementing regulations.

1 (5) REGIONAL NEGOTIATIONS PERMITTED.—

2 Subject to section 614, a regional director may nego-
3 tiate changes to an institutional provider's global
4 budget, including any adjustments to address un-
5 foreseen market shifts related to patient volume.

6 (c) BASELINE RATES AND ADJUSTMENTS.—

7 (1) IN GENERAL.—The Secretary shall use ex-
8 isting prospective payment systems under title
9 XVIII of the Social Security Act to serve as the
10 comparative payment rate system in global budget
11 negotiations described in subsection (b). The Sec-
12 retary shall update such comparative payment rate
13 systems annually.

14 (2) SPECIFICATIONS.—In developing the com-
15 parative payment rate system, the Secretary shall
16 use only the operating base payment rates under
17 each such prospective payment systems with applica-
18 ble adjustments.

19 (3) LIMITATION.—The comparative rate system
20 established under this subsection shall not include
21 the value-based payment adjustments and the cap-
22 ital expenses base payment rates that may be in-
23 cluded in such a prospective payment system.

24 (4) INITIAL YEAR.—In the first year that global
25 budget payments under this Act are available to in-

1 stitutional providers and for purposes of selecting a
2 comparative payment rate system used during initial
3 global budget negotiations for each institutional pro-
4 vider, the Secretary shall take into account the ap-
5 propriate prospective payment system from the most
6 recent year under title XVIII of the Social Security
7 Act to determine what operating base payment the
8 institutional provider would have been paid for cov-
9 ered items and services furnished the preceding year
10 with applicable adjustments, including adjustments
11 due to any public health emergencies in the pre-
12 ceding year, and excluding value-based payment ad-
13 justments, based on such prospective payment sys-
14 tem.

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

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

21 (A) Wages and salary costs for physicians,
22 nurses, and other health care practitioners em-
23 ployed by an institutional provider, including
24 mandatory minimum safe registered nurse-to-

1 patient staffing ratios and optimal staffing lev-
2 els for physicians and other healthcare workers.

3 (B) Wages and salary costs for all ancil-
4 lary staff and services.

5 (C) Costs of all pharmaceutical products
6 administered by health care clinicians at the in-
7 stitutional provider's facilities or through serv-
8 ices provided in accordance with State licensing
9 laws or regulations under which the institu-
10 tional provider operates.

11 (D) Costs for infectious disease response
12 preparedness, including maintenance of a 1-
13 year or 365-day stockpile of personal protective
14 equipment, occupational testing and surveil-
15 lance, medical services for occupational infec-
16 tious disease exposure, and contact tracing.

17 (E) Purchasing and maintenance of med-
18 ical devices, supplies, and other health care
19 technologies, including diagnostic testing equip-
20 ment.

21 (F) Costs of all incidental services nec-
22 essary for safe patient care and handling.

23 (G) Costs of patient care, education, and
24 prevention programs, including occupational
25 health and safety programs, public health pro-

1 grams, and necessary staff to implement such
 2 programs, for the continued education and
 3 health and safety of clinicians and other indi-
 4 viduals employed by the institutional provider.

5 (2) Administrative costs for the institutional
 6 provider.

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

9 (a) MEDICARE FOR ALL FEE SCHEDULE.—

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

17 (A) individual providers;

18 (B) providers in group practices who are
 19 not receiving payments on a salaried basis de-
 20 scribed in section 611(a)(3);

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

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

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

4 (A) the amounts payable for such items
5 and services under title XVIII of the Social Se-
6 curity Act and other Federal health programs;
7 and

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

11 (b) LEVERAGING EXISTING MEDICARE PAYMENT
12 PROCESSES.—

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

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

5 (c) APPLICATION OF CURRENT AND PLANNED PAY-
6 MENT REFORMS.—To the extent the Secretary determines
7 such application is necessary to ensure a smooth and fair
8 transition, the Secretary may apply payment reform ac-
9 tivities planned or implemented with respect to such title
10 XVIII as of the date of the enactment of this Act, includ-
11 ing demonstrations, waivers, or any other provider pay-
12 ment agreements, to benefits under this Act, provided that
13 the Secretary sets forth a process for reviewing such appli-
14 cations and making such determinations that is reason-
15 able, transparent, and documented, and allows for public
16 comment.

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

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

3 (a) STANDARDIZED AND DOCUMENTED REVIEW
 4 PROCESS.—Section 1848(c)(2) of the Social Security Act
 5 (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the
 6 end the following new subparagraph:

7 “(P) STANDARDIZED AND DOCUMENTED
 8 REVIEW PROCESS.—

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

17 “(ii) MINIMUM REQUIREMENTS.—The
 18 standardized process shall include, at a
 19 minimum, methods and criteria for identi-
 20 fying services for review, prioritizing the
 21 review of services, reviewing stakeholder
 22 recommendations, and identifying addi-
 23 tional resources to be considered during
 24 the review process.”.

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

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

3 “(x) PLANNED AND DOCUMENTED
 4 USE OF FUNDS.—For each fiscal year (be-
 5 ginning with the first fiscal year beginning
 6 on or after the date of enactment of this
 7 clause), the Secretary shall provide to Con-
 8 gress a written plan for using the funds
 9 provided under clause (ix) to collect and
 10 use information on physicians’ services in
 11 the determination of relative values under
 12 this subparagraph.”.

13 (c) INTERNAL TRACKING OF REVIEWS.—

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

23 (2) MINIMUM REQUIREMENTS.—The proposal
 24 shall include, at a minimum, plans and a timeline

1 for achieving the ability to systematically and inter-
 2 nally track the following:

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

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

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

9 (D) When relative values are adjusted.

10 (E) The rationale for final relative value
 11 decisions.

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

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

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

19 (e) CONSULTATION WITH MEDICARE PAYMENT AD-
 20 VISORY COMMISSION.—

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

24 (A) in subparagraph (B)(i), by inserting
 25 “in consultation with the Medicare Payment

1 Advisory Commission,” after “The Secretary,”;
2 and

3 (B) in subparagraph (K)(i)(I), as amended
4 by subsection (d)(2), by inserting “, in coordi-
5 nation with the Medicare Payment Advisory
6 Commission,” after “annually”.

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

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

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

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

1 “(Q) PERIODIC AUDIT BY THE COMP-
2 TROLLER GENERAL.—

3 “(i) IN GENERAL.—The Comptroller
4 General of the United States (in this sub-
5 paragraph referred to as the ‘Comptroller
6 General’) shall periodically audit the review
7 by the Secretary of relative values estab-
8 lished under this paragraph for physicians’
9 services.

10 “(ii) ACCESS TO INFORMATION.—The
11 Comptroller General shall have unre-
12 stricted access to all deliberations, records,
13 and data related to the activities carried
14 out under this paragraph, in a timely man-
15 ner, upon request.”.

16 **SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
17 **PROVED DEVICES AND EQUIPMENT.**

18 (a) NEGOTIATED PRICES.—The prices to be paid for
19 covered pharmaceutical products, medical supplies, and
20 medically necessary assistive equipment shall be nego-
21 tiated annually by the Secretary.

22 (b) PRESCRIPTION DRUG FORMULARY.—

23 (1) IN GENERAL.—The Secretary shall establish
24 a prescription drug formulary system, pursuant to
25 the requirements of section 202, which shall encour-

1 age best-practices in prescribing and discourage the
 2 use of ineffective, dangerous, or excessively costly
 3 medications when better alternatives are available.

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

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

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

18 **SEC. 615. PAYMENT PROHIBITIONS; CAPITAL EXPENDI-**
 19 **TURES; SPECIAL PROJECTS.**

20 (a) PROHIBITIONS.—Payments to providers under
 21 this Act may not take into account, include any process
 22 for the provision of funding for, or be used by a provider
 23 for—

24 (1) marketing of the provider;

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

3 (3) any agreement or arrangement described in
 4 section 203(a)(4) of the Labor-Management Report-
 5 ing and Disclosure Act of 1959 (29 U.S.C.
 6 433(a)(4)); or

7 (4) political or other contributions prohibited
 8 under section 317 of the Federal Elections Cam-
 9 paign Act of 1971 (52 U.S.C. 30119(a)(1)).

10 (b) PAYMENTS FOR CAPITAL EXPENDITURES.—

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

20 (2) PRIORITY.—The Secretary shall prioritize
 21 allocation of funding under paragraph (1) to
 22 projects that propose to use such funds to improve
 23 service in a medically underserved area (as defined
 24 in section 330(b)(3) of the Public Health Service
 25 Act (42 U.S.C. 254b(b)(3))) or to address health

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

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

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

(c) PROHIBITION AGAINST CO-MINGLING OPERATING AND CAPITAL FUNDS.—Providers that receive pay-

1 ment under this title shall be prohibited from using, with
2 respect to funds made available under this Act—

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

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

7 (d) PAYMENTS FOR SPECIAL PROJECTS.—

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

1 (2) DISTRIBUTION.—A regional director shall
 2 distribute funds to providers operating in the region
 3 of such director’s jurisdiction in a manner deter-
 4 mined appropriate by the director.

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

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

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

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

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

22 “(b) MONITORING, TRACKING, AND AVAILABILITY OF
 23 DATA.—

24 “(1) IN GENERAL.—In carrying out subsection
 25 (a), the Director of the Office of Health Equity shall

1 monitor, track, and make publicly available data
2 on—

3 “(A) the disproportionate burden of dis-
4 ease and death among people of color,
5 disaggregated by race, major ethnic group,
6 Tribal affiliation, national origin, primary lan-
7 guage use, English proficiency status, immigra-
8 tion status, length of stay in the United States,
9 age, disability, sex (including gender identity
10 and sexual orientation), incarceration, home-
11 lessness, geography, and socioeconomic status;

12 “(B) barriers to health, including such
13 barriers relating to income, education, housing,
14 food insecurity (including availability, access,
15 utilization, and stability), employment status,
16 working conditions, and conditions related to
17 the physical environment (including pollutants
18 and population density);

19 “(C) barriers to health care access, includ-
20 ing—

21 “(i) lack of trust and awareness;

22 “(ii) lack of transportation;

23 “(iii) geography;

24 “(iv) hospital and service closures;

1 “(v) lack of health care infrastructure
2 and facilities; and

3 “(vi) lack of health care professional
4 staffing and recruitment;

5 “(D) disparities in quality of care received,
6 including discrimination in health care settings
7 and the use of racially biased practice guide-
8 lines and algorithms; and

9 “(E) disparities in utilization of care.

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

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

19 “(1) providing recommendations on—

20 “(A) cultural competence, implicit bias,
21 and ethics training with respect to health care
22 workers;

23 “(B) increasing diversity in the health care
24 workforce; and

1 “(C) ensuring sufficient health care profes-
2 sionals and facilities; and

3 “(2) ensuring adequate public health funding at
4 the local and State levels to address health dispari-
5 ties.

6 “(d) CONSULTATION.—In carrying out subsection
7 (a), the Director of the Office of Health Equity, in coordi-
8 nation with the Director of the Indian Health Service,
9 shall consult with Indian Tribes and with Urban Indian
10 organizations on data collection, reporting, and implemen-
11 tation of policies.

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

15 “(1) statistics collected by the Office;

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

18 “(3) health care professional staffing levels and
19 access to facilities.

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

23 “(1) establish and maintain a centralized elec-
24 tronic repository to incorporate data collected across
25 Federal departments and agencies on race, ethnicity,

1 Tribal affiliation, national origin, primary language
 2 use, English proficiency status, immigration status,
 3 length of stay in the United States, age, disability,
 4 sex (including gender identity and sexual orienta-
 5 tion), incarceration, homelessness, geography, and
 6 socioeconomic status; and

7 “(2) make such data available for public use
 8 and analysis.

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

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

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

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

22 “(a) IN GENERAL.—There is established, in the Of-
 23 fice of Health Equity established under section 1712, an
 24 Office of Primary Health Care, to be headed by a Direc-
 25 tor, to ensure coordination and collaboration across the

1 programs and activities of the Department of Health and
2 Human Services with respect to increasing access to high-
3 quality primary health care, particularly in underserved
4 areas and for underserved populations.

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

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

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

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

23 “(1) coordinate, in consultation with the Sec-
24 retary, health professional education policies and

1 goals to achieve the national goals published pursu-
2 ant to subsection (b);

3 “(2) develop and maintain a system to monitor
4 the number and specialties of individuals pursuing
5 careers in, or practicing, primary health care
6 through their health professional education, any
7 postgraduate training, and professional practice;

8 “(3) develop, coordinate, and promote policies
9 that expand the number of primary health care prac-
10 titioners including primary medical, dental, and be-
11 havioral health care providers, registered nurses, and
12 other mid-level practitioners;

13 “(4) recommend appropriate workforce train-
14 ing, technical assistance, and patient protection en-
15 hancements for primary health care practitioners, in-
16 cluding registered nurses, to achieve uniform high
17 quality and patient safety;

18 “(5) provide recommendations on targeted pro-
19 grams and resources for federally qualified health
20 centers, community health centers, rural health cen-
21 ters, behavioral health clinics, and other community-
22 based organizations;

23 “(6) provide recommendations for broader pa-
24 tient referral to additional resources, not limited to
25 health care, and collaboration with other organiza-

1 tions and sectors that influence health outcomes;
 2 and

3 “(7) consult with the Secretary on the alloca-
 4 tion of the special projects budget under section
 5 601(a)(2)(C) of the Medicare for All Act of 2022.

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

8 “(1) to preempt any provision of State law es-
 9 tablishing practice standards or guidelines for health
 10 care professionals, including professional licensing or
 11 practice laws or regulations; or

12 “(2) to require that any State impose additional
 13 educational standards or guidelines for health care
 14 professionals.”.

15 **TITLE VII—UNIVERSAL** 16 **MEDICARE TRUST FUND**

17 **SEC. 701. UNIVERSAL MEDICARE TRUST FUND.**

18 (a) IN GENERAL.—There is hereby created on the
 19 books of the Treasury of the United States a trust fund
 20 to be known as the Universal Medicare Trust Fund (in
 21 this section referred to as the “Trust Fund”). The Trust
 22 Fund shall consist of such gifts and bequests as may be
 23 made and such amounts as may be deposited in, or appro-
 24 priated to, such Trust Fund as provided in this Act.

25 (b) APPROPRIATIONS INTO TRUST FUND.—

1 (1) TAXES.—There are appropriated to the
2 Trust Fund for each fiscal year beginning with the
3 fiscal year which includes the date on which benefits
4 are first available under section 106(a), out of any
5 moneys in the Treasury not otherwise appropriated,
6 amounts equivalent to 100 percent of the net in-
7 crease in revenues to the Treasury which is attrib-
8 utable to the amendments made by sections 801 and
9 902. The amounts appropriated by the preceding
10 sentence shall be transferred from time to time (but
11 not less frequently than monthly) from the general
12 fund in the Treasury to the Trust Fund, such
13 amounts to be determined on the basis of estimates
14 by the Secretary of the Treasury of the taxes paid
15 to or deposited into the Treasury, and proper adjust-
16 ments shall be made in amounts subsequently trans-
17 ferred to the extent prior estimates were in excess
18 of or were less than the amounts that should have
19 been so transferred.

20 (2) CURRENT PROGRAM RECEIPTS.—

21 (A) INITIAL YEAR.—Notwithstanding any
22 other provision of law, there is hereby appro-
23 priated to the Trust Fund for the first fiscal
24 year beginning at least one year after the date
25 of the enactment of this Act, an amount equal

1 to the aggregate amount appropriated for the
2 preceding fiscal year for the following (in-
3 creased by the consumer price index for all
4 urban consumers for the fiscal year involved):

5 (i) The Medicare program under title
6 XVIII of the Social Security Act (other
7 than amounts attributable to any pre-
8 miums under such title).

9 (ii) The Medicaid program under
10 State plans approved under title XIX of
11 such Act.

12 (iii) The Federal Employees Health
13 Benefits program, under chapter 89 of title
14 5, United States Code.

15 (iv) The maternal and child health
16 program (under title V of the Social Secu-
17 rity Act), vocational rehabilitation pro-
18 grams, programs for drug abuse and men-
19 tal health services under the Public Health
20 Service Act, programs providing general
21 hospital or medical assistance, and any
22 other Federal program identified by the
23 Secretary, in consultation with the Sec-
24 retary of the Treasury, to the extent the
25 programs provide for payment for health

1 services the payment of which may be
2 made under this Act.

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

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

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

1 of applying such subsections to this section, the “Board
 2 of Trustees of the Trust Fund” shall mean the “Sec-
 3 retary”.

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

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

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

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

1 **“SEC. 523. PROHIBITION OF EMPLOYEE BENEFITS DUPLI-**
 2 **CATIVE OF MEDICARE FOR ALL PROGRAM**
 3 **BENEFITS; COORDINATION IN CASE OF**
 4 **WORKERS’ COMPENSATION.**

5 “(a) IN GENERAL.—Subject to subsection (b), no em-
 6 ployee benefit plan may provide benefits that duplicate
 7 payment for any items or services for which payment may
 8 be made under the Medicare for All Act of 2022.

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

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

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

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

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

7 (b) CONFORMING AMENDMENT.—Section 4(b) of the
 8 Employee Retirement Income Security Act of 1974 (29
 9 U.S.C. 1003(b)) is amended by adding at the end the fol-
 10 lowing: “Paragraph (3) shall apply subject to section
 11 523(b) (relating to reimbursement of the Medicare for All
 12 Program by workers compensation carriers).”.

13 (c) CLERICAL AMENDMENT.—The table of contents
 14 in section 1 of such Act is amended by inserting after the
 15 item relating to section 522 the following new item:

“Sec. 523. Prohibition of employee benefits duplicative of Medicare for All Pro-
 gram benefits; coordination in case of workers’ compensation.”.

16 **SEC. 802. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
 17 **MENTS UNDER ERISA AND CERTAIN OTHER**
 18 **REQUIREMENTS RELATING TO GROUP**
 19 **HEALTH PLANS.**

20 (a) IN GENERAL.—Part 6 of subtitle B of title I of
 21 the Employee Retirement Income Security Act of 1974
 22 (29 U.S.C. 1161 et seq.) is repealed.

23 (b) CONFORMING AMENDMENTS.—

1 (1) Section 502(a) of such Act (29 U.S.C.
2 1132(a)) is amended—

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

4 (B) by redesignating paragraphs (8), (9),
5 and (10) as paragraphs (7), (8), and (9), re-
6 spectively.

7 (2) Section 502(c)(1) of such Act (29 U.S.C.
8 1132(c)(1)) is amended by striking “paragraph (1)
9 or (4) of section 606,”.

10 (3) Section 514(b) of such Act (29 U.S.C.
11 1144(b)) is amended—

12 (A) in paragraph (7), by striking “section
13 206(d)(3)(B)(i),”; and

14 (B) by striking paragraph (8).

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

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

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

(A) no benefits shall be available under
title XVIII of the Social Security Act for any
item or service furnished beginning on or after
the date on which benefits are first available
under section 106(a);

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

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

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

1 health assistance for any item or service fur-
 2 nished on or after such date.

3 (2) TRANSITION.—In the case of inpatient hos-
 4 pital services and extended care services during a
 5 continuous period of stay which began before the
 6 date on which benefits are first available under sec-
 7 tion 106(a), and which had not ended as of such
 8 date, for which benefits are provided under title
 9 XVIII of the Social Security Act, under a State plan
 10 under title XIX of such Act, or under a State child
 11 health plan under title XXI of such Act, the Sec-
 12 retary shall provide for continuation of benefits
 13 under such title or plan until the end of the period
 14 of stay.

15 (3) CONTINUED COVERAGE OF LONG-TERM
 16 CARE AND OTHER CERTAIN SERVICES UNDER MED-
 17 ICAID.—

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

22 (i) institutional long-term care serv-
 23 ices (as defined in section 1948(b) of such
 24 Act); or

1 (ii) any other service for which bene-
 2 fits are not available under this Act and
 3 which is furnished under a State plan
 4 under title XIX of the Social Security Act
 5 which provided for medical assistance for
 6 such service on January 1, 2022.

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

12 (i) identify services described in sub-
 13 paragraph (A)(ii) with respect to each
 14 State plan; and

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

17 (C) STATE MAINTENANCE OF EFFORT RE-
 18 QUIREMENT.—With respect to any service de-
 19 scribed in subparagraph (A)(ii) that is made
 20 available under a State plan under title XIX of
 21 the Social Security Act, the maintenance of ef-
 22 fort requirements described in section 1948(c)
 23 of such Act (related to eligibility standards and
 24 required expenditures) shall apply to such serv-
 25 ice in the same manner that such requirements

1 apply to institutional long-term care services (as
2 defined in section 1948(b) of such Act).

3 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
4 GRAM.—No benefits shall be made available under chapter
5 89 of title 5, United States Code with respect to items
6 and services furnished to any individual eligible to enroll
7 under this Act.

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

10 (1) IN GENERAL.—Nothing in this Act shall af-
11 fect the eligibility of veterans for the medical bene-
12 fits and services provided under title 38, United
13 States Code, the eligibility of individuals for
14 TRICARE medical benefits and services provided
15 under sections 1079 and 1086 of title 10, United
16 States Code, or of Indians for the medical benefits
17 and services provided by or through the Indian
18 Health Service.

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

22 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**
23 **EXCHANGES.**

24 Effective on the date on which benefits are first avail-
25 able under section 106(a), the Federal and State Ex-

1 changes established pursuant to title I of the Patient Pro-
 2 tection and Affordable Care Act (Public Law 111–148)
 3 shall terminate, and any other provision of law that relies
 4 upon participation in or enrollment through such an Ex-
 5 change, including such provisions of the Internal Revenue
 6 Code of 1986, shall cease to have force or effect.

7 **TITLE X—TRANSITION TO**
 8 **MEDICARE FOR ALL**
 9 **Subtitle A—Improvements to**
 10 **Medicare**

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

14 (a) PROTECTION AGAINST HIGH OUT-OF-POCKET
 15 EXPENDITURES.—Title XVIII of the Social Security Act
 16 (42 U.S.C. 1395 et seq.) is amended by adding at the end
 17 the following new section:

18 “PROTECTION AGAINST HIGH OUT-OF-POCKET
 19 EXPENDITURES

20 “SEC. 1899C. (a) IN GENERAL.—Notwithstanding
 21 any other provision of this title, in the case of an indi-
 22 vidual entitled to, or enrolled for, benefits under part A
 23 or enrolled in part B, if the amount of the out-of-pocket
 24 cost-sharing of such individual for a year (effective the
 25 year beginning January 1 of the year following the date
 26 of enactment of the Medicare for All Act of 2022) equals

1 or exceeds \$1,500, the individual shall not be responsible
 2 for additional out-of-pocket cost-sharing that occurred
 3 during that year.

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

5 “(1) IN GENERAL.—Subject to paragraphs (2)
 6 and (3), in this section, the term ‘out-of-pocket cost-
 7 sharing’ means, with respect to an individual, the
 8 amount of the expenses incurred by the individual
 9 that are attributable to—

10 “(A) coinsurance and copayments applica-
 11 ble under part A or B; or

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

15 “(2) CERTAIN COSTS NOT INCLUDED.—

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

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

25 If an item or service is furnished to an indi-

vidual under this title and is not furnished on an assignment-related basis, any additional expenses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

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

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

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

“(4) For each year (beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2022), the inpatient hospital deductible for the year shall be \$0.”.

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

(A) by striking “and for a subsequent year” and inserting “for each of 2006 through the year that includes the date of enactment of the Medicare for All Act of 2022”; and

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

SEC. 1002. REDUCING MEDICARE PART D ANNUAL OUT-OF-POCKET THRESHOLD AND ELIMINATING COST-SHARING ABOVE THAT THRESHOLD.

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

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

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

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

“(I) IN GENERAL.—Subject to subclause (II), for plan years beginning on or after January 1 following

1 the date of enactment of the Medicare
 2 for All Act of 2022 and before Janu-
 3 ary 1 of the year that is 4 years fol-
 4 lowing such date of enactment, not-
 5 withstanding clauses (i) and (ii), the
 6 ‘annual out-of-pocket threshold’ speci-
 7 fied in this subparagraph is equal to
 8 \$305.

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

18 (b) ELIMINATION OF COST-SHARING.—Section
 19 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C.
 20 1395w–102(b)(4)(A)) is amended—

21 (1) in clause (i)—

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

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

“(I) for plan years 2006 through the plan year ending December 31 following the date of enactment of the Medicare for All Act of 2022, with cost-sharing”;

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

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

“(II) for the plan year beginning January 1 following the date of enactment of the Medicare for All Act of 2022 and the two subsequent plan years, without any cost-sharing.”; and

(2) in clause (ii)—

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

(B) by adding at the end the following new sentence: “The Secretary shall continue to calculate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under

1 this clause, after plan year 2018 for purposes
2 of 1860D–14(a)(1)(D)(iii).”.

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

6 (1) in paragraph (1)—

7 (A) in subparagraph (D)(iii), by striking
8 “1860D–2(b)(4)(A)(i)(I)” and inserting
9 “1860D–2(b)(4)(A)(i)(I)(aa)”; and

10 (B) in subparagraph (E)—

11 (i) in the heading, by inserting
12 “PRIOR TO THE ELIMINATION OF SUCH
13 COST-SHARING FOR ALL INDIVIDUALS”
14 after “THRESHOLD”; and

15 (ii) by striking “The elimination” and
16 inserting “For plan years 2006 through
17 the plan year ending December 31 fol-
18 lowing the date of enactment of the Medi-
19 care for All Act of 2022, the elimination”;
20 and

21 (2) in paragraph (2)(E)—

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

(B) by striking “Subject to” and inserting
 “For plan years 2006 through the plan year
 ending December 31 following the date of en-
 actment of the Medicare for All Act of 2022,
 subject to”; and

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

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

(a) DENTAL SERVICES.—

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

(2) COVERAGE.—

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

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

(ii) in subparagraph (HH), by strik-
 ing the period at the end and inserting “;
 and”; and

1 (iii) by adding at the end the fol-
 2 lowing new subparagraph:

3 “(II) dental services;”.

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

7 (i) by striking “and” before “(DD)”;
 8 and

9 (ii) by inserting before the semicolon
 10 at the end the following: “and (EE) with
 11 respect to dental services described in sec-
 12 tion 1861(s)(2)(II), the amount paid shall
 13 be an amount equal to 80 percent of the
 14 lesser of the actual charge for the services
 15 or the amount determined under the fee
 16 schedule established under section
 17 1848(b).”.

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

22 (b) VISION SERVICES.—

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

1 (A) in subparagraph (HH), by striking
2 “and” at the end;

3 (B) in subparagraph (II), by inserting
4 “and” at the end; and

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

7 “(JJ) vision services;”.

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

11 (A) by striking “and” before “(EE)”; and

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

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

24 (c) HEARING AIDS AND EXAMINATIONS THERE-
25 FOR.—

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

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

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

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

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

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

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

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

1 each month for which the individual meets the re-
 2 quirements of paragraph (2), beginning with the
 3 month following the month in which the individual
 4 meets the requirements of such paragraph, and”;
 5 and

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

9 (b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

19 Section 1882 of the Social Security Act (42 U.S.C.
 20 1395ss) is amended by adding at the end the following
 21 new subsection:

22 “(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELI-
 23 GIBLE MEDICARE BENEFICIARIES.—Notwithstanding
 24 paragraphs (2)(A) and (2)(D) of subsection (s) or any
 25 other provision of this section, on or after the date of en-

1 actment of this subsection, the issuer of a Medicare sup-
 2 plemental policy may not deny or condition the issuance
 3 or effectiveness of a Medicare supplemental policy, or dis-
 4 criminate in the pricing of the policy, because of health
 5 status, claims experience, receipt of health care, or medical
 6 condition in the case of any individual entitled to, or en-
 7 rolled for, benefits under part A and enrolled for benefits
 8 under part B.”.

9 **Subtitle B—Temporary Medicare**
 10 **Buy-In Option and Temporary**
 11 **Public Option**

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

13 (a) IN GENERAL.—Title XVIII of the Social Security
 14 Act (42 U.S.C. 1395c et seq.), as amended by section
 15 1001, is amended by adding at the end the following new
 16 section:

17 “TEMPORARY MEDICARE BUY-IN OPTION FOR CERTAIN
 18 INDIVIDUALS

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

24 “(1) have no effect on the benefits under this
 25 title for individuals who are entitled to, or enrolled

1 for, such benefits other than through this section;
 2 and

3 “(2) have no negative impact on the Federal
 4 Hospital Insurance Trust Fund or the Federal Sup-
 5plementary Medical Insurance Trust Fund (includ-
 6ing the Medicare Prescription Drug Account within
 7such Trust Fund).

8 “(b) OPTION.—

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

12 “(2) PART A, B, AND D BENEFITS.—An indi-
 13 vidual enrolled under this section is entitled to the
 14 same benefits (and shall receive the same protec-
 15tions) under this title as an individual who is enti-
 16tled to benefits under part A and enrolled under
 17parts B and D, including the ability to enroll in a
 18private plan that provides qualified prescription drug
 19coverage.

20 “(3) REQUIREMENTS FOR ELIGIBILITY.—The
 21 requirements described in this paragraph are the fol-
 22lowing:

23 “(A) The individual is a resident of the
 24 United States.

25 “(B) The individual is—

1 “(i) a citizen or national of the United
2 States; or

3 “(ii) an alien lawfully admitted for
4 permanent residence.

5 “(C) The individual is not otherwise enti-
6 tled to benefits under part A or eligible to en-
7 roll under part A or part B.

8 “(D) The individual has attained the appli-
9 cable years of age but has not attained 65 years
10 of age.

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

14 “(A) effective January 1 of the first year
15 following the date of enactment of the Medicare
16 for All Act of 2022, the age of 55;

17 “(B) effective January 1 of the second
18 year following such date of enactment, the age
19 of 45; and

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

22 “(c) ENROLLMENT; COVERAGE.—The Secretary shall
23 establish enrollment periods and coverage under this sec-
24 tion consistent with the principles for establishment of en-
25 rollment periods and coverage for individuals under other

1 provisions of this title. The Secretary shall establish such
 2 periods so that coverage under this section shall first begin
 3 on January 1 of the year on which an individual first be-
 4 comes eligible to enroll under this section.

5 “(d) PREMIUM.—

6 “(1) AMOUNT OF MONTHLY PREMIUMS.—The
 7 Secretary shall, during September of each year (be-
 8 ginning with the first September following the date
 9 of enactment of the Medicare for All Act of 2022),
 10 determine a monthly premium for all individuals en-
 11 rolled under this section. Such monthly premium
 12 shall be equal to $\frac{1}{12}$ of the annual premium com-
 13 puted under paragraph (2)(B), which shall apply
 14 with respect to coverage provided under this section
 15 for any month in the succeeding year.

16 “(2) ANNUAL PREMIUM.—

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

24 “(B) ANNUAL PREMIUM.—The annual pre-
 25 mium under this subsection for months in a

1 year is equal to the average, annual per capita
2 amount estimated under subparagraph (A) for
3 the year.

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

12 “(e) PAYMENT OF PREMIUMS.—

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

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

24 “(f) NOT ELIGIBLE FOR MEDICARE COST-SHARING
25 ASSISTANCE.—An individual enrolled under this section

1 shall not be treated as enrolled under any part of this title
 2 for purposes of obtaining medical assistance for Medicare
 3 cost-sharing or otherwise under title XIX.

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

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

12 “(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—
 13 Coverage provided under this section—

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

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

23 The Secretary shall determine the applicable second
 24 lowest cost silver plan which shall apply to coverage

1 under this section for purposes of section 36B of
 2 such Code.

3 “(3) ELIGIBILITY FOR COST-SHARING SUB-
 4 SIDIES.—For purposes of applying section 1402 of
 5 the Patient Protection and Affordable Care Act (42
 6 U.S.C. 18071)—

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

12 “(B) the Secretary shall be treated as the
 13 issuer of such plan.

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

19 **SEC. 1012. ESTABLISHMENT OF THE MEDICARE TRANSI-**
 20 **TION PLAN.**

21 (a) IN GENERAL.—To carry out the purpose of this
 22 section, for plan years beginning with the first plan year
 23 that begins after the date of enactment of this Act and
 24 ending with the date on which benefits are first available
 25 under section 106(a), the Secretary, acting through the

1 Administrator of the Centers for Medicare & Medicaid (re-
 2 ferred to in this section as the “Administrator”), shall es-
 3 tablish, and provide for the offering through the Ex-
 4 changes, of a public health plan (in this Act referred to
 5 as the “Medicare Transition plan”) that provides afford-
 6 able, high-quality health benefits coverage throughout the
 7 United States.

8 (b) ADMINISTERING THE MEDICARE TRANSI-
 9 TION.—

10 (1) ADMINISTRATOR.—The Administrator shall
 11 administer the Medicare Transition plan in accord-
 12 ance with this section.

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

22 (3) OFFERING THROUGH EXCHANGES.—The
 23 Medicare Transition plan shall be made available
 24 only through the Exchanges, and shall be available
 25 to individuals wishing to enroll and to qualified em-

1 employers (as defined in section 1312(f)(2) of the Pa-
 2 tient Protection and Affordable Care Act (42 U.S.C.
 3 18032)) who wish to make such plan available to
 4 their employees.

5 (4) ELIGIBILITY TO PURCHASE.—Any United
 6 States resident may enroll in the Medicare Transi-
 7 tion plan.

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

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

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

16 (d) PROVIDERS AND REIMBURSEMENT RATES.—

17 (1) IN GENERAL.—With respect to the reim-
 18 bursement provided to health care providers for cov-
 19 ered benefits, as described in section 201, provided
 20 under the Medicare Transition plan, the Adminis-
 21 trator shall reimburse such providers at rates deter-
 22 mined for equivalent items and services under the
 23 original Medicare fee-for-service program under
 24 parts A and B of title XVIII of the Social Security
 25 Act (42 U.S.C. 1395c et seq.). For items and serv-

ices covered under the Medicare Transition plan but not covered under such parts A and B, the Administrator shall reimburse providers at rates set by the Administrator in a manner consistent with the manner in which rates for other items and services were set under the original Medicare fee-for-service program.

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

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

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

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

(3) PARTICIPATING PROVIDERS.—

1 (A) IN GENERAL.—A health care provider
 2 that is a participating provider of services or
 3 supplier under the Medicare program under
 4 title XVIII of the Social Security Act (42
 5 U.S.C. 1395 et seq.) or under a State Medicaid
 6 plan under title XIX of such Act (42 U.S.C.
 7 1396 et seq.) on the date of enactment of this
 8 Act shall be a participating provider in the
 9 Medicare Transition plan.

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

17 (e) PREMIUMS.—

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

21 (A) may vary according to family or indi-
 22 vidual coverage, age, and tobacco status (con-
 23 sistent with clauses (i), (iii), and (iv) of section
 24 2701(a)(1)(A) of the Public Health Service Act
 25 (42 U.S.C. 300gg(a)(1)(A))); and

1 (B) shall take into account the cost-shar-
 2 ing reductions and premium tax credits which
 3 will be available with respect to the plan under
 4 section 1402 of the Patient Protection and Af-
 5 fordable Care Act (42 U.S.C. 18071) and sec-
 6 tion 36B of the Internal Revenue Code of 1986,
 7 as amended by subsection (g).

8 (2) LIMITATION.—Variation in premium rates
 9 of the Medicare Transition plan by rating area, as
 10 described in clause (ii) of section 2701(a)(1)(A)(iii)
 11 of the Public Health Service Act (42 U.S.C.
 12 300gg(a)(1)(A)) is not permitted.

13 (f) TERMINATION.—This section shall cease to have
 14 force or effect on the date on which benefits are first avail-
 15 able under section 106(a).

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

17 (1) PREMIUM ASSISTANCE TAX CREDITS.—

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

spectively, and by inserting after subparagraph
(B) the following new subparagraph:

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

“(i) IN GENERAL.—In the case of a
taxpayer who is covered, or whose spouse
or dependent (as defined in section 152) is
covered, by the Medicare Transition plan
established under section 1002(a) of the
Medicare for All Act of 2022 for all
months in the taxable year, subparagraph
(A) shall be applied without regard to ‘but
does not exceed 400 percent’. The pre-
ceding sentence shall not apply to any tax-
able year to which subparagraph (E) ap-
plies.

“(ii) ENROLLEES IN MEDICAID NON-
EXPANSION STATES.—In the case of a tax-
payer residing in a State which (as of the
date of the enactment of the Medicare for
All Act of 2022) does not provide for eligi-
bility under clause (i)(VIII) or (ii)(XX) of
section 1902(a)(10)(A) of the Social Secu-
rity Act for medical assistance under title
XIX of such Act (or a waiver of the State

1 plan approved under section 1115) who is
 2 covered, or whose spouse or dependent (as
 3 defined in section 152) is covered, by the
 4 Medicare Transition plan established under
 5 section 1002(a) of the Medicare for All Act
 6 of 2022 for all months in the taxable year,
 7 subparagraphs (A) and (B) shall be ap-
 8 plied by substituting ‘0 percent’ for ‘100
 9 percent’ each place it appears.”.

10 (B) PREMIUM ASSISTANCE AMOUNTS FOR
 11 TAXPAYERS ENROLLED IN MEDICARE TRANSI-
 12 TION PLAN.—

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

16 (I) by redesignating clauses (ii)
 17 and (iii) as clauses (iii) and (iv), re-
 18 spectively;

19 (II) by striking “clause (ii)” in
 20 clause (i) and inserting “clauses (ii)
 21 and (iii)”; and

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

24 “(ii) SPECIAL RULES FOR TAXPAYERS
 25 ENROLLED IN MEDICARE TRANSITION

1 PLAN.—In the case of a taxpayer who is
 2 covered, or whose spouse or dependent (as
 3 defined in section 152) is covered, by the
 4 Medicare Transition plan established under
 5 section 1002(a) of the Medicare for All Act
 6 of 2022 for all months in the taxable year
 7 the applicable percentage for any taxable
 8 year shall be determined in the same man-
 9 ner as under clause (i), except that the fol-
 10 lowing table shall apply in lieu of the table
 11 contained in such clause:

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

12 The preceding sentence shall not apply to
 13 any taxable year to which clause (iv) ap-
 14 plies.”.

15 (ii) CONFORMING AMENDMENT.—Sub-
 16 clause (I) of clause (iii) of section
 17 36B(b)(3) of such Code, as redesignated
 18 by subparagraph (A)(i), is amended by in-
 19 serting “, and determined after the appli-
 20 cation of clause (ii)” after “after applica-
 21 tion of this clause”.

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

5 (A) by inserting “, or in the Medicare
 6 Transition plan established under section
 7 1002(a) of the Medicare for All Act of 2022,”
 8 after “coverage” in paragraph (1);

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

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

16 (D) by striking the flush language; and

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

19 “(2) SPECIAL RULES.—

20 “(A) INDIVIDUALS LAWFULLY PRESENT.—

21 In the case of an individual described in section
 22 36B(c)(1)(B) of the Internal Revenue Code of
 23 1986, the individual shall be treated as having
 24 household income equal to 100 percent of the

1 poverty line for a family of the size involved for
2 purposes of applying this section.

3 “(B) MEDICARE TRANSITION PLAN EN-
4 ROLLEES IN MEDICAID NON-EXPANSION
5 STATES.—In the case of an individual residing
6 in a State which (as of the date of the enact-
7 ment of the Medicare for All Act of 2022) does
8 not provide for eligibility under clause (i)(VIII)
9 or (ii)(XX) of section 1902(a)(10)(A) of the So-
10 cial Security Act for medical assistance under
11 title XIX of such Act (or a waiver of the State
12 plan approved under section 1115) who enrolls
13 in such Medicare Transition plan, the preceding
14 sentence, paragraph (1)(B), and paragraphs
15 (1)(A)(i) and (2)(A) of subsection (c) shall each
16 be applied by substituting ‘0 percent’ for ‘100
17 percent’ each place it appears.

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

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

(h) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

5 The Secretary shall ensure that all individuals en-
6 rolled in, or who seek to enroll in, a group health plan,
7 health insurance coverage offered by a health insurance
8 issuer, or the plan established under section 1002 during
9 the transition period of this Act are protected from disrup-
10 tions in their care during the transition period.

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

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

18 **SEC. 1023. DEFINITIONS.**

19 In this subtitle, the terms “health insurance cov-
20 erage”, “health insurance issuer”, and “group health
21 plans” have the meanings given such terms in section
22 2791 of the Public Health Service Act (42 U.S.C. 300gg–
23 91).

TITLE XI—MISCELLANEOUS

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

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

(1) in subparagraph (A)—

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

(B) by inserting “, and to \$6,200 on January 1, 2022” before the period;

(2) in subparagraph (B)—

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

(B) by inserting “, and to \$4,100 on January 1, 2022” before the period; and

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

“(C) Beginning with December of 2022, whenever the dollar amounts in effect under paragraphs (1)(A) and (2)(A) of this subsection are increased for a month by a percentage under section 1617(a)(2), each of the dollar amounts in effect under this paragraph shall be increased, effective with such month, by the same percentage (and

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

5 **SEC. 1102. DEFINITIONS.**

6 In this Act—

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

9 (2) the term “State” means a State, the Dis-
10 trict of Columbia, or a territory of the United
11 States; and

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

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