USA Senator Bernie Sanders
Explains HIS "Democratic Socialist Health CARE Plan"

US Senate Bill 1804 (115th US Congress

**TEXAS PUBLIC RADIO :: ** Originally published on March 18, 2019 9:56 am

https://www.tpr.org/post/bernie-sanders-pledges-do-better-job-explaining-socialism

"... **Interviewer MARTIN:** So if we take the Democratic presidential field, you've got candidates now who sound like Bernie Sanders. So why do you need to run?

Bernie SANDERS: (Laughter) Well, maybe the more appropriate question is why do they need to run? (Laughter). ..."

Susan: Cute but UNtrue Answer Bernie. In fact, Bernie Sanders' HealthCare Bill "protects" companies that sell "Health Insurance".

In fact, the sale of "Health Insurance" - as described in his Bill > "Senate 1804" - will lead to a "double-standard" for Health CARE delivery – in the USA: That is, hospitals, doctors, etc. for "Rich" people - AND, hospitals, doctors, etc. for "Poor" people.

Bernie Sanders health Care bill : US Congress

https://www.congress.gov/bill/115th-congress/senate-bill/1804

TEXT – of the Bill :
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Susan searched "insurance" - insurance > The word occurs 23 times.

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SEC. 104. NON-DISCRIMINATION.

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

SEC. 106. EFFECTIVE DATE OF BENEFITS.

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

(b) Coverage For Children.—

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

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

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

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

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

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

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

SEC. 202. NO COST-SHARING.

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

(b) Exceptions.—The Secretary may—

(1) impose cost-sharing with respect to services provided under section 1946 of the Social Security Act, as added by section 204; and

(2) set a cost-sharing schedule for prescription drugs and biological products—

SEC. 303. USE OF PRIVATE CONTRACTS.

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

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

(2) for which the provider receives—

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

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

(b) Beneficiary Protections.—

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

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

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

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

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

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

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

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

SEC. 405. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

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

SEC. 601. NATIONAL HEALTH BUDGET.

(a) National Health Budget.—

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

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

(A) Quality assessment activities under title V.

(B) Health professional education expenditures.

(C) Administrative costs.

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

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

(F) Capital expenditures.

(G) Prevention and public health activities.

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

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

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

(4) TEMPORARY WORKER ASSISTANCE.—For up to 5 years following the date on which benefits first become available as described in section 106(a), up to 1 percent of the budget may be allocated to

programs providing assistance to workers who perform functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of this Act.

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

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

(b) Appropriations Into Trust Fund.—

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

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

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

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

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

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

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

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

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

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

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

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

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

“(a) In General.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2017.

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

“(c) Definitions.—In this subsection—

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

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

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)—

TITLE X—TRANSITION

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

SEC. 1001. LOWERING THE MEDICARE AGE.

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

"TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN INDIVIDUALS

"Sec. 1899C. (a) Option.—

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

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

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

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

"(B) The individual is—

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

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

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

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

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

"(A) effective January 1 of the first year following the date of enactment of the Medicare for All Act of 2017, the age of 55;

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

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

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

"(c) Premium.—

"(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (beginning with the first September following the date of enactment of the Medicare for All Act of 2017), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1⁄12 of the annual

premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

"(2) ANNUAL PREMIUM.—

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

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

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

"(d) Payment Of Premiums.—

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

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

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“(d) Payment Of Premiums.—

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

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

“(e) Not Eligible For Medicare Cost-Sharing Assistance.—An individual enrolled under this section shall not be treated as enrolled under any part

of this title for purposes of obtaining medical assistance for Medicare cost-sharing or otherwise under title XIX.

“(f) Treatment In Relation To The Affordable Care Act.—

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

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

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

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

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

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

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

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

“(g) Guaranteed Issue Of Medigap Policies Upon First Enrollment And Each Subsequent Enrollment.—In the case of an individual who enrolls under this section (including an individual who was previously enrolled under this section), paragraphs (2)(A), (2)(D), (3)(B)(ii), and (3)(B)(vi) of section 1882(s)—

“(1) shall be applied by substituting ‘the applicable year of age (as defined in section 1899C(a)(4))’ for ‘65 years of age’;

“(2) if the individual was enrolled under this section and subsequently disenrolls, shall apply each time the individual subsequently reenrolls under this section as if the individual had attained the applicable year of age (as defined in subsection (a)(4)) on the date of such reenrollment (and as if the individual had never previously enrolled in a Medicare supplemental policy); and

"(3) shall be applied as if this section had not been enacted (and as if the individual had never previously enrolled in a Medicare supplemental policy) when the individual attains 65 years of age.

"(h) No Effect On Benefits For Individuals Otherwise Eligible Or On Trust Funds.—The Secretary shall implement the provisions of this section in such a manner to ensure that such provisions—

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

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

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

Subtitle B—Transitional Medicare Reforms

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

(a) Protection Against High Out-Of-Pocket Expenditures.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 1001, is amended by adding at the end the following new section:

"PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES

"Sec. 1899D. (a) In General.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (effective the year beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2017) equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing occurred during that year.

"(b) Out-Of-Pocket Cost-Sharing Defined.—

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

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

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

“(2) CERTAIN COSTS NOT INCLUDED.—

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

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

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

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

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

TITLE XI—MISCELLANEOUS

SEC. 1101. DEFINITIONS.

[End of Bill TEXT copy] **TEXT – of the Bill :**
https://www.congress.gov/bill/115th-congress/senate-bill/1804/text