SOURCE: https://www.sanders.senate.gov/download/medicare-for-all-act-of-2019?id=0DD31317-EF09-4349-A0D4-0510991EF748&download=1&inline=file
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116TH CONGRESS

1ST SESSION S. ll

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

IN THE SENATE OF THE UNITED STATES

LIIIIIIIII

Mr. SANDERS (for himself, Ms. BALDWIN, Mr. BLUMENTHAL, Mr. BOOKER,

Mrs. GILLIBRAND, Ms. HARRIS, Mr. LEAHY, Mr. MARKEY, Mr.

MERKLEY, Mr. SCHATZ, Mr. UDALL, Ms. WARREN, Mr. WHITEHOUSE,

and Ms. HIRONO) introduced the following bill; which was read twice and

referred to the Committee on lllllllllll

- 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 2019’’.

6 (b) TABLE OF CONTENT.—The table of contents for

7 this Act is as follows:

Sec. 1. Short title; table of contents.

TABLE OF CONTENTS

(END OF TABLE OF CONTENTS)

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

SEC. 101. ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM.

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

SEC. 102. UNIVERSAL ENTITLEMENT.

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

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

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

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

SEC. 103. FREEDOM OF CHOICE.

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

SEC. 104. NON-DISCRIMINATION.

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

(b) CLAIMS OF DISCRIMINATION.—

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

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

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as ap9 propriate.

SEC. 105. ENROLLMENT.

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

(1) include a process for the automatic enroll15 ment of individuals at the time of birth in the United States or upon the establishment of resi17 dency in the United States;

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

(3) include a process for the enrollment of indi22 viduals made eligible for health care services under section 102(b).

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

1 under this Act, the Secretary shall provide for the issuance

2 of a Universal Medicare card that shall be used for pur3 poses of identification and processing of claims for bene4 fits under this program. The card shall not include an in5 dividual's Social Security number.

6 SEC. 106. EFFECTIVE DATE OF BENEFITS.

7 (a) IN GENERAL.—Except as provided in subsection

8 (b), benefits shall first be available under this Act for

9 items and services furnished on January 1 of the fourth

10 calendar year that begins after the date of enactment of

11 this Act.

12 (b) COVERAGE FOR CHILDREN.—

13 (1) IN GENERAL.—For any eligible individual

14 who has not yet attained the age of 19, benefits

15 shall first be available under this Act for items and

16 services furnished on January 1 of the first calendar

17 year that begins after the date of enactment of this

18 Act.

19 (2) OPTION TO CONTINUE IN OTHER COVERAGE

20 DURING TRANSITION PERIOD.—Any person who is

21 eligible to receive benefits as described in paragraph

22 (1) may opt to maintain any coverage described in

23 section 901, private health insurance coverage, or

24 coverage offered pursuant to subtitle A of title X

1 (including the amendments made by such subtitle)

2 until the effective date described in subsection (a).

3 SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

4 (a) IN GENERAL.—Beginning on the effective date

5 described in section 106(a), it shall be unlawful for—

6 (1) a private health insurer to sell health insur7 ance coverage that duplicates the benefits provided

8 under this Act; or

9 (2) an employer to provide benefits for an em10 ployee, former employee, or the dependents of an

11 employee or former employee that duplicate the ben12 efits provided under this Act.

13 (b) CONSTRUCTION.—Nothing in this Act shall be

14 construed as prohibiting the sale of health insurance cov15 erage for any additional benefits not covered by this Act,

16 including additional benefits that an employer may provide

17 to employees or their dependents, or to former employees

18 or their dependents.

19 TITLE II—COMPREHENSIVE BEN20 EFITS, INCLUDING PREVEN21 TIVE BENEFITS AND BENE22 FITS FOR LONG-TERM CARE

23 SEC. 201. COMPREHENSIVE BENEFITS.

24 (a) IN GENERAL.—Subject to the other provisions of

25 this title and titles IV through IX, individuals enrolled for

1 benefits under this Act are entitled to have payment made

2 by the Secretary to an eligible provider for the following

3 items and services if medically necessary or appropriate

4 for the maintenance of health or for the diagnosis, treat5 ment, or rehabilitation of a health condition:

6 (1) Hospital services, including inpatient and

7 outpatient hospital care, including 24-hour-a-day

8 emergency services and inpatient prescription drugs.

9 (2) Ambulatory patient services.

10 (3) Primary and preventive services, including

11 chronic disease management.

12 (4) Prescription drugs, medical devices, biologi13 cal products, including outpatient prescription drugs,

14 medical devices, and biological products.

15 (5) Mental health and substance abuse treat16 ment services, including inpatient care.

17 (6) Laboratory and diagnostic services.

18 (7) Comprehensive reproductive, maternity, and

19 newborn care.

20 (8) Pediatrics, including early and periodic

21 screening, diagnostic, and treatment services (as de22 fined in section 1905(r) of the Social Security Act

23 (42 U.S.C. 1396d(r))).

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

1 (10) Short-term rehabilitative and habilitative

2 services and devices.

3 (11) Emergency services and transportation.

4 (12) Necessary transportation to receive health

5 care services for individuals with disabilities and low6 income individuals.

7 (13) Home and community-based long-term

8 services and supports (to be provided in accordance

9 with the requirements for home and community10 based settings under sections 441.530 and 441.710

11 of title 42, Code of Federal Regulations), includ12 ing—

13 (A) services described in paragraphs (7),

14 (8), (13), (19), and (24) of section 1905(a) of

15 the Social Security Act (42 U.S.C. 1396d(a));

16 (B) home and community-based services

17 described in subsection (c)(4)(B) of section

18 1915 of the Social Security Act (including ha19 bilitation services defined in subsection (c)(5) of

20 such section);

21 (C) self-directed home and community22 based services described in subsection (i) of sec23 tion 1915 of the Social Security Act;

1 (D) self-directed personal assistance serv2 ices (as defined in subsection (j)(4)(A) of sec3 tion 1915 of the Social Security Act); and

4 (E) home and community-based attendant

5 services and supports described in subsection

6 (k) of section 1915 of the Social Security Act.

7 (b) REVISION AND ADJUSTMENT.—The Secretary

8 shall, on a regular basis, evaluate whether the benefits

9 package should be improved or adjusted to promote the

10 health of beneficiaries, account for changes in medical

11 practice or new information from medical research, or re12 spond to other relevant developments in health science,

13 and shall make recommendations to Congress regarding

14 any such improvements or adjustments.

15 (c) COMPLEMENTARY AND INTEGRATIVE MEDI16 CINE.—

17 (1) IN GENERAL.—In carrying out subsection

18 (b), the Secretary shall consult with the persons de19 scribed in paragraph (1) with respect to—

20 (A) identifying specific complementary and

21 integrative medicine practices that, on the basis

22 of research findings or promising clinical inter23 ventions, are appropriate to include in the bene24 fits package

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

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

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

(B) the Commissioner of Food and Drugs.

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

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

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

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

1 SEC. 202. NO COST-SHARING.

2 (a) IN GENERAL.—The Secretary shall ensure that

3 no cost-sharing, including deductibles, co**insurance**, copay4 ments, or similar charges, be imposed on an individual for

5 any benefits provided under this Act, except as described

6 in subsection (b).

7 (b) EXCEPTIONS.—The Secretary may set a cost8 sharing schedule for prescription drugs and biological

9 products—

10 (1) provided that—

11 (A) such schedule is evidence-based and

12 encourages the use of generic drugs;

13 (B) such cost-sharing does not apply to

14 preventive drugs;

15 (C) such cost-sharing does not exceed $200

16 annually per individual, adjusted annually for

17 inflation; and

18 (D) such cost-sharing is not imposed on in19 dividuals with a household income equal to or

20 below 200 percent of the poverty line for a fam21 ily of the size involved; and

22 (2) under which the Secretary may exempt

23 brand-name drugs from consideration in determining

24 whether an individual has reached any out-of-pocket

25 limit if a generic version of such drug is available.

1 (c) NO BALANCE BILLING.—Notwithstanding con2 tracts in accordance with section 303, no provider may

3 impose a charge to an enrolled individual for covered serv4 ices for which benefits are provided under this Act.

5 SEC. 203. EXCLUSIONS AND LIMITATIONS.

6 (a) IN GENERAL.—Benefits for services are not avail7 able under this Act unless the services meet the standards

8 specified in section 201(a), as defined by the Secretary.

9 (b) TREATMENT OF EXPERIMENTAL SERVICES AND

10 DRUGS.—

11 (1) IN GENERAL.—In applying subsection (a),

12 the Secretary shall make national coverage deter13 minations with respect to services that are experi14 mental in nature. Such determinations shall be con15 sistent with the national coverage determination

16 process as defined in section 1869(f)(1)(B) of the

17 Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

18 (2) APPEALS PROCESS.—The Secretary shall

19 establish a process by which individuals can appeal

20 coverage decisions. The process shall, as much as is

21 feasible, follow process for appeals under the Medi22 care program described in section 1869 of the Social

23 Security Act (42 U.S.C. 1395ff).

24 (c) APPLICATION OF PRACTICE GUIDELINES.—In the

25 case of services for which the Department of Health and

1 Human Services has recognized a national practice guide2 line, the services are considered to meet the standards

3 specified in section 201(a) if they have been provided in

4 accordance with such guideline. For purposes of this sub5 section, a service shall be considered to have been provided

6 in accordance with a practice guideline if the health care

7 provider providing the service exercised appropriate pro8 fessional discretion to deviate from the guideline in a man9 ner authorized or anticipated by the guideline.

10 SEC. 204. COVERAGE OF INSTITUTIONAL LONG-TERM CARE

11 SERVICES UNDER MEDICAID.

12 Title XIX of the Social Security Act (42 U.S.C. 1396

13 et seq.) is amended by inserting the following section after

14 section 1946:

15 ''STATE PLAN FOR PROVIDING INSTITUTIONAL LONG16 TERM CARE SERVICES

17 ''SEC. 1947. (a) IN GENERAL.—For quarters begin18 ning on or after date on which benefits are first available

19 under section 106(a) of the Medicare for All Act of 2019,

20 notwithstanding any other provision of this title—

21 ''(1) a State plan for medical assistance shall

22 provide for making medical assistance available for

23 services that are institutional long-term care services

24 in a manner consistent with this section; and

25 ''(2) no payment to a State shall be made

26 under this title with respect to expenditures incurred

by the State in providing medical assistance on or
after such date for services that are not—
‘‘(A) institutional long-term care services;
or
‘‘(B) other services for which benefits are
not available under the Medicare for All Act of
2019 and which are furnished under a State
plan for medical assistance which provided for
medical assistance for such services on Sep10 tember 1, 2018.
‘‘(b) INSTITUTIONAL LONG-TERM CARE SERVICES
DEFINED.—In this section, the term ‘institutional long13 term care services’ means the following:
‘‘(1) Nursing facility services for individuals 21
years of age or over described in subparagraph (A)
of section 1905(a)(4).
‘‘(2) Inpatient services for individuals 65 years
of age or over provided in an institution for mental
disease described in section 1905(a)(14).
‘‘(3) Intermediate care facility services de21 scribed in section 1905(a)(15).
‘‘(4) Inpatient psychiatric hospital services for
individuals under age 21 described in section
1905(a)(16).

1 ‘‘(5) Nursing facility services described in sec2 tion 1905(a)(29).

3 ‘‘(c) MAINTENANCE OF EFFORT.—

4 ‘‘(1) ELIGIBILITY STANDARDS.—

5 ‘‘(A) IN GENERAL.—Beginning on the date

6 described in subsection (a), no payment may be

7 made under section 1903 with respect to med8 ical assistance provided under a State plan for

9 medical assistance if the State adopts income,

10 resource, or other standards and methodologies

11 for purposes of determining an individual’s eli12 gibility for medical assistance under the State

13 plan that are more restrictive than those ap14 plied as of January 1, 2019.

15 ‘‘(B) INDEXING OF AMOUNTS OF INCOME

16 AND RESOURCE STANDARDS.—In determining

17 whether a State has adopted income or resource

18 standards that are more restrictive than the

19 standards which applied as of January 1, 2019,

20 the Secretary shall deem the amount of any

21 such standard that was applied as of such date

22 to be increased by the percentage increase in

23 the medical care component of the consumer

24 price index for all urban consumers (U.S. city

25 average) from September of 2018 to September

of the fiscal year for which the Secretary is
making such determination.
''(2) EXPENDITURES.—
''(A) IN GENERAL.—For each fiscal year
or portion of a fiscal year that occurs during
the period that begins on the first day of the
first fiscal quarter that begins on or after the
date on which benefits are first available under
section 106(a) of the Medicare for All Act of
2019, as a condition of receiving payments
under section 1903(a), a State shall make ex12 penditures for medical assistance for services
that are institutional long-term care services in
an amount that is not less than the expenditure
floor determined for the State and fiscal year
(or portion of a fiscal year) under subparagraph
(B).
''(B) EXPENDITURE FLOOR.—
''(i) IN GENERAL.—For each fiscal
year or portion of a fiscal year described in
subparagraph (A), the Secretary shall de22 termine for each State an expenditure floor
that shall be equal to—
''(I) the amount of the State's
expenditures for fiscal year 2018 on

1 medical assistance for institutional

2 long-term care services; increased by

3 ‘‘(II) the growth factor deter4 mined under subclause (ii).

5 ‘‘(ii) GROWTH FACTOR.—For each fis6 cal year or portion of a fiscal year de7 scribed in subparagraph (A), the Secretary

8 shall, not later than September 1 of the

9 fiscal year preceding such fiscal year or

10 portion of a fiscal year, determine a

11 growth factor for each State that takes

12 into account—

13 ‘‘(I) the percentage increase in

14 health care costs in the State;

15 ‘‘(II) the total amount expended

16 by the State for the previous fiscal

17 year on medical assistance for institu18 tional long-term care services;

19 ‘‘(III) the increase, if any, in the

20 total population of the State from

21 July of 2018 to July of the fiscal year

22 preceding the fiscal year involved;

23 ‘‘(IV) the increase, if any, in the

24 population of individuals aged 65 and

25 older of the State from July of 2018

1 to July of the fiscal year preceding

2 the fiscal year involved; and

3 ‘‘(V) the decrease, if any, in the

4 population of the State that requires

5 medical assistance for institutional

6 long-term care services that is attrib7 utable to the availability of coverage

8 for the services described in section

9 201(a)(13) of the Medicare for All

10 Act of 2019.

11 ‘‘(iii) PRORATION RULE.—Any

12 amount determined under this subpara13 graph for a portion of a fiscal year shall be

14 prorated based on the length of such por15 tion of a fiscal year relative to a complete

16 fiscal year.

17 ‘‘(d) NONAPPLICATION OF CERTAIN REQUIRE18 MENTS.—Beginning on the date described in subsection

19 (a), any provision of this title requiring a State plan for

20 medical assistance to make available medical assistance

21 for services that are not institutional long-term care serv22 ices or services described in section 901(a)(3)(A)(ii) of the

23 Medicare for All Act of 2019 shall have no effect.’’.

1 SEC. 205. PROHIBITING RECOVERY OF CORRECTLY PAID

2 MEDICAID BENEFITS.

3 Section 1917 of the Social Security Act (42 U.S.C.

4 1396p) is amended—

5 (1) by amending subsection (a) to read as fol6 lows:

7 ''(a) No lien may be imposed against the property

8 of any individual prior to his death on account of medical

9 assistance paid or to be paid on his behalf under the State

10 plan, except pursuant to the judgment of a court on ac11 count of benefits incorrectly paid on behalf of such indi12 vidual.''; and

13 (2) by amending subsection (b) to read as fol14 lows:

15 ''(b) No adjustment or recovery of any medical assist16 ance correctly paid on behalf of an individual under the

17 State plan may be made.''.

18 SEC. 206. STATE STANDARDS.

19 (a) IN GENERAL.—Nothing in this Act shall prohibit

20 individual States from setting additional standards, with

21 respect to eligibility, benefits, and minimum provider

22 standards, consistent with the purposes of this Act, pro23 vided that such standards do not restrict eligibility or re24 duce access to benefits or services.

25 (b) RESTRICTIONS ON PROVIDERS.—With respect to

26 any individuals or entities certified to provide services cov-

1 ered under section 201(a)(7), a State may not prohibit

2 an individual or entity from participating in the program

3 under this Act, for reasons other than the ability of the

4 individual or entity to provide such services.

5 TITLE III—PROVIDER

6 PARTICIPATION

7 SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

8 (a) IN GENERAL.—An individual or other entity fur9 nishing any covered service under this Act is not a quali10 fied provider unless the individual or entity—

11 (1) is a qualified provider of the services under

12 section 302;

13 (2) has filed with the Secretary a participation

14 agreement described in subsection (b); and

15 (3) meets, as applicable, such other qualifica16 tions and conditions with respect to a provider of

17 services under title XVIII of the Social Security Act

18 as described in section 1866 of the Social Security

19 Act (42 U.S.C. 1395cc).

20 (b) REQUIREMENTS IN PARTICIPATION AGREE21 MENT.—

22 (1) IN GENERAL.—A participation agreement

23 described in this subsection between the Secretary

24 and a provider shall provide at least for the fol25 lowing:

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

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

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

(i) quality review by designated entities;

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

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

1 (iv) such other purposes as the Sec2 retary may specify.

3 (D) In the case of a provider that is not

4 an individual, the provider agrees not to employ

5 or use for the provision of health services any

6 individual or other provider that has had a par7 ticipation agreement under this subsection ter8 minated for cause.

9 (E) In the case of a provider paid under

10 a fee-for-service basis, the provider agrees to

11 submit bills and any required supporting docu12 mentation relating to the provision of covered

13 services within 30 days after the date of pro14 viding such services.

15 (2) TERMINATION OF PARTICIPATION AGREE16 MENT.—

17 (A) IN GENERAL.—Participation agree18 ments may be terminated, with appropriate no19 tice—

20 (i) by the Secretary for failure to meet

21 the requirements of this Act; or

22 (ii) by a provider.

23 (B) TERMINATION PROCESS.—Providers

24 shall be provided notice and a reasonable oppor25 tunity to correct deficiencies before the Sec-

1 retary terminates an agreement unless a more

2 immediate termination is required for public

3 safety or similar reasons.

4 (C) PROVIDER PROTECTIONS.—

5 (i) PROHIBITION.—The Secretary may

6 not terminate a participation agreement or

7 in any other way discriminate against, or

8 cause to be discriminated against, any cov9 ered provider or authorized representative

10 of the provider, on account of such pro11 vider or representative—

12 (I) providing, causing to be pro13 vided, or being about to provide or

14 cause to be provided to the provider,

15 the Federal Government, or the attor16 ney general of a State information re17 lating to any violation of, or any act

18 or omission the provider or represent19 ative reasonably believes to be a viola20 tion of, any provision of this title (or

21 an amendment made by this title);

22 (II) testifying or being about to

23 testify in a proceeding concerning

24 such violation;

(III) assisting or participating, or

being about to assist or participate, in

such a proceeding; or

(IV) objecting to, or refusing to

participate in, any activity, policy,

practice, or assigned task that the

provider or representative reasonably

believes to be in violation of any provision of this Act (including any amendment made by this Act), or any order,

rule, regulation, standard, or ban

under this Act (including any amendment made by this Act).

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he

or she has been discriminated against in

violation of this section may seek relief in

accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section

2087(b) of title 15, United States Code.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

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

1 (1) all the requirements of State law to provide

2 such services; and

3 (2) applicable requirements of Federal law to

4 provide such services.

5 (b) MINIMUM PROVIDER STANDARDS.—

6 (1) IN GENERAL.—The Secretary shall estab7 lish, evaluate, and update national minimum stand8 ards to ensure the quality of services provided under

9 this Act and to monitor efforts by States to ensure

10 the quality of such services. A State may also estab11 lish additional minimum standards which providers

12 shall meet with respect to services provided in such

13 State.

14 (2) NATIONAL MINIMUM STANDARDS.—The na15 tional minimum standards under paragraph (1) shall

16 be established for institutional providers of services

17 and individual health care practitioners. Except as

18 the Secretary may specify in order to carry out this

19 Act, a hospital, skilled nursing facility, or other in20 stitutional provider of services shall meet standards

21 for such a provider under the Medicare program

22 under title XVIII of the Social Security Act (42

23 U.S.C. 1395 et seq.). Such standards also may in24 clude, where appropriate, elements relating to—

25 (A) adequacy and quality of facilities;

1 (B) training and competence of personnel

2 (including continuing education requirements);

3 (C) comprehensiveness of service;

4 (D) continuity of service;

5 (E) patient satisfaction, including waiting

6 time and access to services; and

7 (F) performance standards, including orga8 nization, facilities, structure of services, effi9 ciency of operation, and outcome in palliation,

10 improvement of health, stabilization, cure, or

11 rehabilitation.

12 (3) TRANSITION IN APPLICATION.—If the Sec13 retary provides for additional requirements for pro14 viders under this subsection, any such additional re15 quirement shall be implemented in a manner that

16 provides for a reasonable period during which a pre17 viously qualified provider is permitted to meet such

18 an additional requirement.

19 (4) ABILITY TO PROVIDE SERVICES.—With re20 spect to any entity or provider certified to provide

21 services described in section 201(a)(7), the Secretary

22 may not prohibit such entity or provider from par23 ticipating for reasons other than its ability to pro24 vide such services.

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

SEC. 303. USE OF PRIVATE CONTRACTS.

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

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

(2) for which the provider receives—

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

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

(b) BENEFICIARY PROTECTIONS.—

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

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1 (A) the contract is in writing and is signed
2 by the beneficiary before any item or service is
3 provided pursuant to the contract;
4 (B) the contract contains the items de5 scribed in paragraph (2); and
6 (C) the contract is not entered into at a
7 time when the beneficiary is facing an emer8 gency health care situation.
9 (2) ITEMS REQUIRED TO BE INCLUDED IN CON10 TRACT.—Any contract to provide items and services
11 to which subsection (a) applies shall clearly indicate
12 to the beneficiary that by signing such contract the
13 beneficiary—
14 (A) agrees not to submit a claim (or to re15 quest that the provider submit a claim) under
16 this Act for such items or services even if such
17 items or services are otherwise covered by this
18 Act;
19 (B) agrees to be responsible, whether
20 through **insurance** offered under section 107(b)
21 or otherwise, for payment of such items or serv22 ices and understands that no reimbursement
23 will be provided under this Act for such items
24 or services;

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

(D) if the provider is a non-participating provider, acknowledges that the beneficiary has the right to have such items or services pro7 vided by other providers for whom payment would be made under this Act; and

(E) acknowledges that the provider is pro10 viding services outside the scope of the program under this Act.

(c) PROVIDER REQUIREMENTS.—

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

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

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

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

1 scribed in paragraph (1)(B) for any such item

2 or service) during the 1–year period beginning

3 on the date the affidavit is signed; and

4 (C) be filed with the Secretary no later

5 than 10 days after the first contract to which

6 such affidavit applies is entered into.

7 (3) ENFORCEMENT.—If a physician or practi8 tioner signing an affidavit described in paragraph

9 (2) knowingly and willfully submits a claim under

10 this title for any item or service provided during the

11 1-year period described in paragraph (2)(B) (or re12 ceives any reimbursement or amount described in

13 subsection (a)(2) for any such item or service) with

14 respect to such affidavit—

15 (A) this subsection shall not apply with re16 spect to any items and services provided by the

17 physician or practitioner pursuant to any con18 tract on and after the date of such submission

19 and before the end of such period; and

20 (B) no payment shall be made under this

21 title for any item or service furnished by the

22 physician or practitioner during the period de23 scribed in clause (i) (and no reimbursement or

24 payment of any amount described in subsection

1 (a)(2) shall be made for any such item or serv2 ice).

3 TITLE IV—ADMINISTRATION

4 Subtitle A—General

5 Administration Provisions

6 SEC. 401. ADMINISTRATION.

7 (a) GENERAL DUTIES OF THE SECRETARY.—

8 (1) IN GENERAL.—The Secretary shall develop

9 policies, procedures, guidelines, and requirements to

10 carry out this Act, including related to—

11 (A) eligibility for benefits;

12 (B) enrollment;

13 (C) benefits provided;

14 (D) provider participation standards and

15 qualifications, as described in title III;

16 (E) levels of funding;

17 (F) methods for determining amounts of

18 payments to providers of covered services, con19 sistent with subtitle B;

20 (G) the determination of medical necessity

21 and appropriateness with respect to coverage of

22 certain services;

23 (H) planning for capital expenditures and

24 service delivery;

1 (I) planning for health professional edu2 cation funding;

3 (J) encouraging States to develop regional

4 planning mechanisms; and

5 (K) any other regulations necessary to

6 carry out the purpose of this Act.

7 (2) REGULATIONS.—Regulations authorized by

8 this Act shall be issued by the Secretary in accord9 ance with section 553 of title 5, United States Code.

10 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE11 PORT; STUDIES.—

12 (1) UNIFORM REPORTING STANDARDS.—

13 (A) IN GENERAL.—The Secretary shall es14 tablish uniform State reporting requirements

15 and national standards to ensure an adequate

16 national database containing information per17 taining to health services practitioners, ap18 proved providers, the costs of facilities and

19 practitioners providing such services, the qual20 ity of such services, the outcomes of such serv21 ices, and the equity of health among population

22 groups. Such standards shall include, to the

23 maximum extent feasible without compromising

24 patient privacy, health outcome measures, and

25 to the maximum extent feasible without exces-

1 sively burdening providers, the measures de2 scribed in subparagraphs (D) through (F) of
3 subsection (a)(1).
4 (B) REPORTS.—The Secretary shall regu5 larly analyze information reported to it and
6 shall define rules and procedures to allow re7 searchers, scholars, health care providers, and
8 others to access and analyze data for purposes
9 consistent with quality and outcomes research,
10 without compromising patient privacy.
11 (2) ANNUAL REPORT.—Beginning January 1 of
12 the second year beginning after the effective date of
13 this Act, the Secretary shall annually report to Con14 gress on the following:
15 (A) The status of implementation of the
16 Act.
17 (B) Enrollment under this Act.
18 (C) Benefits under this Act.
19 (D) Expenditures and financing under this
20 Act.
21 (E) Cost-containment measures and
22 achievements under this Act.
23 (F) Quality assurance.
36

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

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

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

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

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

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

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

(N) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Secretary may, either directly or by contract—

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

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

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

(c) AUDITS.—

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

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

SEC. 402. CONSULTATION.

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

1 medical schools and academic health centers, consumer

2 and patient groups, and labor and business organizations

3 in the formulation of guidelines, regulations, policy initia4 tives, and information gathering to ensure the broadest

5 and most informed input in the administration of this Act.

6 Nothing in this Act shall prevent the Secretary from

7 adopting guidelines developed by such a private entity if,

8 in the Secretary's judgment, such guidelines are generally

9 accepted as reasonable and prudent and consistent with

10 this Act.

11 SEC. 403. REGIONAL ADMINISTRATION.

12 (a) COORDINATION WITH REGIONAL OFFICES.—The

13 Secretary shall establish and maintain regional offices to

14 promote adequate access to, and efficient use of, tertiary

15 care facilities, equipment, and services. Wherever possible,

16 the Secretary shall incorporate regional offices of the Cen17 ters for Medicare & Medicaid Services for this purpose.

18 (b) APPOINTMENT OF REGIONAL AND STATE DIREC19 TORS.—In each such regional office there shall be—

20 (1) one regional director appointed by the Sec21 retary;

22 (2) for each State in the region, a deputy direc23 tor; and

24 (3) one deputy director to represent the Native

25 American and Alaska Native tribes in the region.

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

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

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

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

SEC. 404. BENEFICIARY OMBUDSMAN.

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

(b) DUTIES.—The Beneficiary Ombudsman shall—

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

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

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

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

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

SEC. 405. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

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

1 ters pertaining to health, the Secretary shall direct the ac2 tivities of the Department of Health and Human Services

3 toward contributions to the health of the people com4 plementary to this Act.

5 Subtitle B—Control Over Fraud

6 and Abuse

7 SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL

8 FRAUD AND ABUSE UNDER UNIVERSAL MEDI9 CARE PROGRAM.

10 The following sections of the Social Security Act shall

11 apply to this Act in the same manner as they apply to

12 State medical assistance plans under title XIX of such

13 Act:

14 (1) Section 1128 (relating to exclusion of indi15 viduals and entities).

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

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

18 (4) Section 1124 (relating to disclosure of own19 ership and related information).

20 (5) Section 1126 (relating to disclosure of cer21 tain owners).

22 TITLE V—QUALITY ASSESSMENT

23 SEC. 501. QUALITY STANDARDS.

24 (a) IN GENERAL.—All standards and quality meas25 ures under this Act shall be performed by the Center for

1 Clinical Standards and Quality of the Centers for Medi2 care & Medicaid Services (referred to in this title as the

3 ‘‘Center’’), in coordination with the Agency for Healthcare

4 Research and Quality and other offices of the Department

5 of Health and Human Services.

6 (b) DUTIES OF THE CENTER.—The Center shall per7 form the following duties:

8 (1) PRACTICE GUIDELINES.—The Center shall

9 review and evaluate each practice guideline devel10 oped under part B of title IX of the Public Health

11 Service Act. The Center shall determine whether the

12 guideline should be recognized as a national practice

13 guideline.

14 (2) STANDARDS OF QUALITY, PERFORMANCE

15 MEASURES, AND MEDICAL REVIEW CRITERIA.—The

16 Center shall review and evaluate each standard of

17 quality, performance measure, and medical review

18 criterion developed under part B of title IX of the

19 Public Health Service Act (42 U.S.C. 299 et seq.).

20 The Center shall determine whether the standard,

21 measure, or criterion is appropriate for use in as22 sessing or reviewing the quality of services provided

23 by health care institutions or health care profes24 sionals. In evaluating such standards, the Center

25 shall consider the evidentiary basis for the standard,

1 and the validity, reliability, and feasibility of meas2 uring the standard.

3 (3) PROFILING OF PATTERNS OF PRACTICE;

4 IDENTIFICATION OF OUTLIERS.—The Center shall

5 adopt methodologies for profiling the patterns of

6 practice of health care professionals and for identi7 fying and notifying outliers.

8 (4) CRITERIA FOR ENTITIES CONDUCTING

9 QUALITY REVIEWS.—The Center shall develop min10 imum criteria for competence for entities that can

11 qualify to conduct ongoing and continuous external

12 quality reviews in the administrative regions. Such

13 criteria shall require such an entity to be adminis14 tratively independent of the individual or board that

15 administers the region and shall ensure that such

16 entities do not provide financial incentives to review17 ers to favor one pattern of practice over another.

18 The Center shall ensure coordination and reporting

19 by such entities to ensure national consistency in

20 quality standards.

21 (5) REPORTING.—The Center shall report to

22 the Secretary annually specifically on findings from

23 outcomes research and development of practice

24 guidelines that may affect the Secretary's deter-

1 mination of coverage of services under section

2 401(a)(1)(G).

3 SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

4 (a) EVALUATING DATA COLLECTION AP5 PROACHES.—The Center shall evaluate approaches for the

6 collection of data under this Act, to be performed in con7 junction with existing quality reporting requirements and

8 programs under this Act, that allow for the ongoing, accu9 rate, and timely collection of data on disparities in health

10 care services and performance on the basis of race, eth11 nicity, gender, geography, or socioeconomic status. In con12 ducting such evaluation, the Secretary shall consider the

13 following objectives:

14 (1) Protecting patient privacy.

15 (2) Minimizing the administrative burdens of

16 data collection and reporting on providers under this

17 Act.

18 (3) Improving Universal Medicare Program

19 data on race, ethnicity, gender, geography, and so20 cioeconomic status.

21 (b) REPORTS TO CONGRESS.—

22 (1) REPORT ON EVALUATION.—Not later than

23 18 months after the date on which benefits first be24 come available as described in section 106(a), the

25 Center shall submit to Congress and the Secretary

1 a report on the evaluation conducted under sub2 section (a). Such report shall, taking into consider3 ation the results of such evaluation—

4 (A) identify approaches (including defining

5 methodologies) for identifying and collecting

6 and evaluating data on health care disparities

7 on the basis of race, ethnicity, gender, geog8 raphy, or socioeconomic status under the Uni9 versal Medicare Program; and

10 (B) include recommendations on the most

11 effective strategies and approaches to reporting

12 quality measures, as appropriate, on the basis

13 of race, ethnicity, gender, geography, or socio14 economic status.

15 (2) REPORT ON DATA ANALYSES.—Not later

16 than 4 years after the submission of the report

17 under subsection (b)(1), and 4 years thereafter, the

18 Center shall submit to Congress and the Secretary

19 a report that includes recommendations for improv20 ing the identification of health care disparities based

21 on the analyses of data collected under subsection

22 (c).

23 (c) IMPLEMENTING EFFECTIVE APPROACHES.—Not

24 later than 2 years after the date on which benefits first

25 become available as described in section 106(a), the Sec-

1 retary shall implement the approaches identified in the re2 port submitted under subsection (b)(1) for the ongoing,

3 accurate, and timely collection and evaluation of data on

4 health care disparities on the basis of race, ethnicity, gen5 der, geography, or socioeconomic status.

6 TITLE VI—HEALTH BUDGET;

7 PAYMENTS; COST CONTAIN8 MENT MEASURES

9 Subtitle A—Budgeting

10 SEC. 601. NATIONAL HEALTH BUDGET.

11 (a) NATIONAL HEALTH BUDGET.—

12 (1) IN GENERAL.—By not later than September

13 1 of each year, beginning with the year prior to the

14 date on which benefits first become available as de15 scribed in section 106(a), the Secretary shall estab16 lish a national health budget, which specifies the

17 total expenditures to be made for covered health

18 care services under this Act.

19 (2) DIVISION OF BUDGET INTO COMPONENTS.—

20 In addition to the cost of covered health services, the

21 national health budget shall consist of at least the

22 following components:

23 (A) Quality assessment activities under

24 title V.

(B) Health professional education expendi2 tures.

(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 com10 ponent''), 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 com16 ponents in a manner that—

(A) ensures a fair allocation for quality as18 sessment activities; and

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

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

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

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

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

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

1 Subtitle B—Payments to Providers

2 SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL

3 PROVIDERS.

4 (a) APPLICATION OF PAYMENT PROCESSES UNDER

5 TITLE XVIII.—Except as otherwise provided in this sec6 tion, the Secretary shall establish, by regulation, fee

7 schedules that establish payment amounts for benefits

8 under this Act in a manner that is consistent with proc9 esses for determining payments for items and services

10 under title XVIII of the Social Security Act (42 U.S.C.

11 1395 et seq.), including the application of the provisions

12 of, and amendments made by, section 612.

13 (b) APPLICATION OF CURRENT AND PLANNED PAY14 MENT REFORMS.—Any payment reform activities or dem15 onstrations planned or implemented with respect to such

16 title XVIII as of the date of the enactment of this Act

17 shall apply to benefits under this Act, including any re18 form activities or demonstrations planned or implemented

19 under the provisions of, or amendments made by, the

20 Medicare Access and CHIP Reauthorization Act of 2015

21 (Public Law 114–10) and the Patient Protection and Af22 fordable Care Act (Public Law 111–148).

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

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

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

''(i) IN GENERAL.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall estab13 lish, document, and make publicly available a standardized process for reviewing the relative values of physicians' services under this paragraph.

''(ii) MINIMUM REQUIREMENTS.—The standardized process shall include, at a minimum, methods and criteria for identi20 fying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying addi23 tional resources to be considered during the review process.''.

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

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 (be5 ginning with the first fiscal year beginning

6 on or after the date of enactment of this

7 clause), the Secretary shall provide to Con8 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 Sec16 retary shall submit to Congress a proposed plan for

17 systematically and internally tracking its review of

18 the relative values of physicians’ services, such as by

19 establishing an internal database, under section

20 1848(c)(2) of the Social Security Act (42 U.S.C.

21 1395w–4(c)(2)), as amended by this section.

22 (2) MINIMUM REQUIREMENTS.—The proposal

23 shall include, at a minimum, plans and a timeline

24 for achieving the ability to systematically and inter25 nally track the following:

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

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

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

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

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

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

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

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

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

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

1 (B) in subparagraph (K)(i)(I), as amended

2 by subsection (d)(2), by inserting ‘‘, in coordi3 nation with the Medicare Payment Advisory

4 Commission,’’ after ‘‘annually’’.

5 (2) CONFORMING AMENDMENTS.—Section 1805

6 of the Social Security Act (42 U.S.C. 1395b–6) is

7 amended—

8 (A) in subsection (b)(1)(A), by inserting

9 the following before the semicolon at the end:

10 ‘‘and including coordinating with the Secretary

11 in accordance with section 1848(c)(2) to sys12 tematically review the relative values established

13 for physicians’ services, identify potentially

14 misvalued services, and propose adjustments to

15 the relative values for physicians’ services’’; and

16 (B) in subsection (e)(1), in the second sen17 tence, by inserting ‘‘or the Ranking Minority

18 Member’’ after ‘‘the Chairman’’.

19 (f) PERIODIC AUDIT BY THE COMPTROLLER GEN20 ERAL.—Section 1848(c)(2) of the Social Security Act (42

21 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is

22 amended by adding at the end the following new subpara23 graph:

24 ‘‘(Q) PERIODIC AUDIT BY THE COMP25 TROLLER GENERAL.—

1 ‘‘(i) IN GENERAL.—The Comptroller

2 General of the United States (in this sub3 paragraph referred to as the ‘Comptroller

4 General’) shall periodically audit the review

5 by the Secretary of relative values estab6 lished under this paragraph for physicians’

7 services.

8 ‘‘(ii) ACCESS TO INFORMATION.—The

9 Comptroller General shall have unre10 stricted access to all deliberations, records,

11 and nonproprietary data related to the ac12 tivities carried out under this paragraph,

13 in a timely manner, upon request.’’.

14 SEC. 613. OFFICE OF PRIMARY HEALTH CARE.

15 (a) IN GENERAL.—There is established within the

16 Agency for Healthcare Research and Quality an Office of

17 Primary Health Care, responsible for coordinating with

18 the Secretary, the Health Resources and Services Admin19 istration, and other offices in the Department as nec20 essary, in order to—

21 (1) coordinate health professional education

22 policies and goals, in consultation with the Secretary

23 to achieve the national goals specified in subsection

24 (b);

1 (2) develop and maintain a system to monitor

2 the number and specialties of individuals through

3 their health professional education, any postgraduate

4 training, and professional practice;

5 (3) develop, coordinate, and promote policies

6 that expand the number of primary care practi7 tioners, registered nurses, midlevel practitioners, and

8 dentists; and

9 (4) recommend the appropriate training, edu10 cation, technical assistance, and patient advocacy en11 hancements of primary care health professionals, in12 cluding registered nurses, to achieve uniform high

13 quality and patient safety.

14 (b) NATIONAL GOALS.—Not later than 1 year after

15 the date of enactment of this Act, the Office of Primary

16 Health Care shall set forth national goals to increase ac17 cess to high quality primary health care, particularly in

18 underserved areas and for underserved populations.

19 SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND AP20 PROVED DEVICES AND EQUIPMENT.

21 (a) NEGOTIATED PRICES.—The prices to be paid for

22 covered pharmaceuticals, medical supplies, and medically

23 necessary assistive equipment shall be negotiated annually

24 by the Secretary.

25 (b) PRESCRIPTION DRUG FORMULARY.—

1 (1) IN GENERAL.—The Secretary shall establish

2 a prescription drug formulary system, which shall

3 encourage best-practices in prescribing and discour4 age the use of ineffective, dangerous, or excessively

5 costly medications when better alternatives are avail6 able.

7 (2) PROMOTION OF USE OF GENERICS.—The

8 formulary under this subsection shall promote the

9 use of generic medications to the greatest extent

10 possible.

11 (3) FORMULARY UPDATES AND PETITION

12 RIGHTS.—The formulary under this subsection shall

13 be updated frequently and clinicians and patients

14 may petition the Secretary to add new pharma15 ceuticals or to remove ineffective or dangerous medi16 cations from the formulary.

17 (4) USE OF OFF-FORMULARY MEDICATIONS.—

18 The Secretary shall promulgate rules regarding the

19 use of off-formulary medications which allow for pa20 tient access but do not compromise the formulary.

21 TITLE VII—UNIVERSAL

22 MEDICARE TRUST FUND

23 SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

24 (a) IN GENERAL.—There is hereby created on the

25 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.

1 (2) CURRENT PROGRAM RECEIPTS.—Notwith2 standing any other provision of law, there are hereby
3 appropriated to the Trust Fund for each fiscal year,
4 beginning with the first fiscal year beginning on or
5 after the effective date of benefits under section 106,
6 the amounts that would otherwise have been appro7 priated to carry out the following programs:
8 (A) The Medicare program under title
9 XVIII of the Social Security Act (other than
10 amounts attributable to any premiums under
11 such title).
12 (B) The Medicaid program, under State
13 plans approved under title XIX of such Act.
14 (C) The Federal employees health benefit
15 program, under chapter 89 of title 5, United
16 States Code.
17 (D) The TRICARE program, under chap18 ter 55 of title 10, United States Code.
19 (E) The maternal and child health pro20 gram (under title V of the Social Security Act),
21 vocational rehabilitation programs, programs
22 for drug abuse and mental health services
23 under the Public Health Service Act, programs
24 providing general hospital or medical assistance,
25 and any other Federal program identified by

1 the Secretary, in consultation with the Sec2 retary of the Treasury, to the extent the pro3 grams provide for payment for health services

4 the payment of which may be made under this

5 Act.

6 (3) RESTRICTIONS SHALL NOT APPLY.—Any

7 other provision of law in effect on the date of enact8 ment of this Act restricting the use of Federal funds

9 for any reproductive health service shall not apply to

10 monies in the Trust Fund.

11 (c) INCORPORATION OF PROVISIONS.—The provisions

12 of subsections (b) through (i) of section 1817 of the Social

13 Security Act (42 U.S.C. 1395i) shall apply to the Trust

14 Fund under this section in the same manner as such pro15 visions applied to the Federal Hospital Insurance Trust

16 Fund under such section 1817, except that, for purposes

17 of applying such subsections to this section, the ''Board

18 of Trustees of the Trust Fund'' shall mean the ''Sec
19 retary''.

20 (d) TRANSFER OF FUNDS.—Any amounts remaining

21 in the Federal Hospital **Insurance** Trust Fund under sec
22 tion 1817 of the Social Security Act (42 U.S.C. 1395i)

23 or the Federal Supplementary Medical **Insurance** Trust

24 Fund under section 1841 of such Act (42 U.S.C. 1395t)

25 after the payment of claims for items and services fur-

1 nished under title XVIII of such Act have been completed,

2 shall be transferred into the Universal Medicare Trust

3 Fund under this section.

4 TITLE VIII—CONFORMING

5 AMENDMENTS TO THE EM6 PLOYEE RETIREMENT IN7 COME SECURITY ACT OF 1974

8 SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA9 TIVE OF BENEFITS UNDER THE UNIVERSAL

10 MEDICARE PROGRAM; COORDINATION IN

11 CASE OF WORKERS' COMPENSATION.

12 (a) IN GENERAL.—Part 5 of subtitle B of title I of

13 the Employee Retirement Income Security Act of 1974

14 (29 U.S.C. 1131 et seq.) is amended by adding at the end

15 the following new section:

16 ''SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLI17 CATIVE OF UNIVERSAL MEDICARE PROGRAM

18 BENEFITS; COORDINATION IN CASE OF

19 WORKERS' COMPENSATION.

20 ''(a) IN GENERAL.—Subject to subsection (b), no em21 ployee benefit plan may provide benefits that duplicate

22 payment for any items or services for which payment may

23 be made under the Medicare for All Act of 2019.

24 ''(b) REIMBURSEMENT.—Each workers compensation

25 carrier that is liable for payment for workers compensa-

1 tion services furnished in a State shall reimburse the Uni2 versal Medicare Program for the cost of such services.

3 ‘‘(c) DEFINITIONS.—In this subsection—

4 ‘‘(1) the term ‘workers compensation carrier’

5 means an **insurance** company that underwrite work
6 ers compensation medical benefits with respect to 1

7 or more employers and includes an employer or fund

8 that is financially at risk for the provision of work9 ers compensation medical benefits;

10 ‘‘(2) the term ‘workers compensation medical

11 benefits’ means, with respect to an enrollee who is

12 an employee subject to the workers compensation

13 laws of a State, the comprehensive medical benefits

14 for work-related injuries and illnesses provided for

15 under such laws with respect to such an employee;

16 and

17 ‘‘(3) the term ‘workers compensation services’

18 means items and services included in workers com19 pensation medical benefits and includes items and

20 services (including rehabilitation services and long21 term-care services) commonly used for treatment of

22 work-related injuries and illnesses.’’.

23 (b) CONFORMING AMENDMENT.—Section 4(b) of the

24 Employee Retirement Income Security Act of 1974 (29

25 U.S.C. 1003(b)) is amended by adding at the end the fol-

1 lowing: ‘‘Paragraph (3) shall apply subject to section

2 522(b) (relating to reimbursement of the Universal Medi3 care Program by workers compensation carriers).’’.

4 (c) CLERICAL AMENDMENT.—The table of contents

5 in section 1 of such Act is amended by inserting after the

6 item relating to section 521 the following new item:

‘‘Sec 522. Prohibition of employee benefits duplicative of Universal Medicare

Program benefits; coordination in case of workers’ compensation.’’.

7 SEC. 802. REPEAL OF CONTINUATION COVERAGE REQUIRE8 MENTS UNDER ERISA AND CERTAIN OTHER

9 REQUIREMENTS RELATING TO GROUP

10 HEALTH PLANS.

11 (a) IN GENERAL.—Part 6 of subtitle B of title I of

12 the Employee Retirement Income Security Act of 1974

13 (29 U.S.C. 1161 et seq.) is repealed.

14 (b) CONFORMING AMENDMENTS.—

15 (1) Section 502(a) of such Act (29 U.S.C.

16 1132(a)) is amended—

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

18 (B) by redesignating paragraphs (8), (9),

19 and (10) as paragraphs (7), (8), and (9), re20 spectively.

21 (2) Section 502(c)(1) of such Act (29 U.S.C.

22 1132(c)(1)) is amended by striking ‘‘paragraph (1)

23 or (4) of section 606,’’.

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

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

(B) by striking paragraph (8).

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

SEC. 803. EFFECTIVE DATE OF TITLE.

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

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

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

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

1 the effective date of benefits under section

2 106(a);

3 (B) no individual is entitled to medical as4 sistance under a State plan approved under

5 title XIX of such Act for any item or service

6 furnished on or after such date;

7 (C) no individual is entitled to medical as8 sistance under a State child health plan under

9 title XXI of such Act for any item or service

10 furnished on or after such date; and

11 (D) no payment shall be made to a State

12 under section 1903(a) or 2105(a) of such Act

13 with respect to medical assistance or child

14 health assistance for any item or service fur15 nished on or after such date.

16 (2) TRANSITION.—In the case of inpatient hos17 pital services and extended care services during a

18 continuous period of stay which began before the ef19 fective date of benefits under section 106, and which

20 had not ended as of such date, for which benefits

21 are provided under title XVIII of the Social Security

22 Act, under a State plan under title XIX of such Act,

23 or under a State child health plan under title XXI

24 such Act, the Secretary of Health and Human Serv-

ices shall provide for continuation of benefits under
such title or plan until the end of the period of stay.
(3) SERVICES UNDER MEDICAID.—
(A) IN GENERAL.—This subsection shall
not apply to entitlement to medical assistance
provided under title XIX of the Social Security
Act for—
(i) institutional long-term care serv9 ices (as defined in section 1947(b) of such
Act); or
(ii) any other service for which bene12 fits are not available under this Act and
which is furnished under a State plan
under title XIX of the Social Security Act
which provided for medical assistance for
such service on January 1, 2019.
(B) COORDINATION BETWEEN SECRETARY
AND STATES.—The Secretary shall coordinate
with the directors of State agencies responsible
for administering State plans under title XIX
of the Social Security Act to—
(i) identify services described in sub23 paragraph (A)(ii) with respect to each
State plan; and

1 (ii) ensure that such services continue

2 to be made available under such plan.

3 (C) MAINTENANCE OF EFFORT REQUIRE4 MENT.—With respect to any service described

5 in subparagraph (A)(ii) that is made available

6 under a State plan under title XIX of the So7 cial Security Act, the maintenance of effort re8 quirements described in section 1947(c) of such

9 Act (related to eligibility standards and re10 quired expenditures) shall apply to such service

11 in the same manner that such requirements

12 apply to institutional long-term care services (as

13 defined in section 1947(b) of such Act).

14 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO15 GRAM.—No benefits shall be made available under chapter

16 89 of title 5, United States Code, for any part of a cov17 erage period occurring on or after the effective date.

18 (c) TRICARE.—No benefits shall be made available

19 under sections 1079 and 1086 of title 10, United States

20 Code, for items or services furnished on or after the effec21 tive date.

22 (d) TREATMENT OF BENEFITS FOR VETERANS AND

23 NATIVE AMERICANS.—

24 (1) IN GENERAL.—Nothing in this Act shall af25 fect the eligibility of veterans for the medical bene-

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

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

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

Effective on the date described in section 106, the Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Pub13 lic Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

TITLE X—TRANSITION

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

SEC. 1001. LOWERING THE MEDICARE AGE.

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

1 ‘‘TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN

2 INDIVIDUALS

3 ‘‘SEC. 1899C. (a) OPTION.—

4 ‘‘(1) IN GENERAL.—Every individual who meets

5 the requirements described in paragraph (3) shall be

6 eligible to enroll under this section.

7 ‘‘(2) PART A, B, AND D BENEFITS.—An indi8 vidual enrolled under this section is entitled to the

9 same benefits (and shall receive the same protec10 tions) under this title as an individual who is enti11 tled to benefits under part A and enrolled under

12 parts B and D, including the ability to enroll in a

13 Medicare Advantage plan that provides qualified pre14 scription drug coverage (an MA–PD plan).

15 ‘‘(3) REQUIREMENTS FOR ELIGIBILITY.—The

16 requirements described in this paragraph are the fol17 lowing:

18 ‘‘(A) The individual is a resident of the

19 United States.

20 ‘‘(B) The individual is—

21 ‘‘(i) a citizen or national of the United

22 States; or

23 ‘‘(ii) an alien lawfully admitted for

24 permanent residence.

1 ‘‘(C) The individual is not otherwise enti2 tled to benefits under part A or eligible to en3 roll under part A or part B.

4 ‘‘(D) The individual has attained the appli5 cable years of age but has not attained 65 years

6 of age.

7 ‘‘(4) APPLICABLE YEARS OF AGE DEFINED.—

8 For purposes of this section, the term ‘applicable

9 years of age’ means—

10 ‘‘(A) effective January 1 of the first year

11 following the date of enactment of the Medicare

12 for All Act of 2019, the age of 55;

13 ‘‘(B) effective January 1 of the second

14 year following such date of enactment, the age

15 of 45; and

16 ‘‘(C) effective January 1 of the third year

17 following such date of enactment, the age of 35.

18 ‘‘(b) ENROLLMENT; COVERAGE.—The Secretary shall

19 establish enrollment periods and coverage under this sec20 tion consistent with the principles for establishment of en21 rollment periods and coverage for individuals under other

22 provisions of this title. The Secretary shall establish such

23 periods so that coverage under this section shall first begin

24 on January 1 of the year on which an individual first be25 comes eligible to enroll under this section.

1 ‘‘(c) PREMIUM.—

2 ‘‘(1) AMOUNT OF MONTHLY PREMIUMS.—The

3 Secretary shall, during September of each year (be4 ginning with the first September following the date

5 of enactment of the Medicare for All Act of 2019),

6 determine a monthly premium for all individuals en7 rolled under this section. Such monthly premium

shall be equal to 1 8⁄12 of the annual premium com9 puted under paragraph (2)(B), which shall apply

10 with respect to coverage provided under this section

11 for any month in the succeeding year.

12 ‘‘(2) ANNUAL PREMIUM.—

13 ‘‘(A) COMBINED PER CAPITA AVERAGE FOR

14 ALL MEDICARE BENEFITS.—The Secretary shall

15 estimate the average, annual per capita amount

16 for benefits and administrative expenses that

17 will be payable under parts A, B, and D (in18 cluding, as applicable, under part C) in the year

19 for all individuals enrolled under this section.

20 ‘‘(B) ANNUAL PREMIUM.—The annual pre21 mium under this subsection for months in a

22 year is equal to the average, annual per capita

23 amount estimated under subparagraph (A) for

24 the year.

1 ‘‘(3) INCREASED PREMIUM FOR CERTAIN PART

2 C AND D PLANS.—Nothing in this section shall pre3 clude an individual from choosing a Medicare Advan4 tage plan or a prescription drug plan which requires

5 the individual to pay an additional amount (because

6 of supplemental benefits or because it is a more ex7 pensive plan). In such case the individual would be

8 responsible for the increased monthly premium.

9 ‘‘(d) PAYMENT OF PREMIUMS.—

10 ‘‘(1) IN GENERAL.—Premiums for enrollment

11 under this section shall be paid to the Secretary at

12 such times, and in such manner, as the Secretary

13 determines appropriate.

14 ‘‘(2) DEPOSIT.—Amounts collected by the Sec15 retary under this section shall be deposited in the

16 Federal Hospital **Insurance** Trust Fund and the

17 Federal Supplementary Medical **Insurance** Trust

18 Fund (including the Medicare Prescription Drug Ac
19 count within such Trust Fund) in such proportion

20 as the Secretary determines appropriate.

21 ‘‘(e) NOT ELIGIBLE FOR MEDICARE COST-SHARING

22 ASSISTANCE.—An individual enrolled under this section

23 shall not be treated as enrolled under any part of this title

24 for purposes of obtaining medical assistance for Medicare

25 cost-sharing or otherwise under title XIX.

1 ‘‘(f) TREATMENT IN RELATION TO THE AFFORDABLE
2 CARE ACT.—
3 ‘‘(1) SATISFACTION OF INDIVIDUAL MAN4 DATE.—For purposes of applying section 5000A of
5 the Internal Revenue Code of 1986, the coverage
6 provided under this section constitutes minimum es7 sential coverage under subsection (f)(1)(A)(i) of
8 such section 5000A.
9 ‘‘(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—
10 Coverage provided under this section—
11 ‘‘(A) shall be treated as coverage under a
12 qualified health plan in the individual market
13 enrolled in through the Exchange where the in14 dividual resides for all purposes of section 36B
15 of the Internal Revenue Code of 1986 other
16 than subsection (c)(2)(B) thereof; and
17 ‘‘(B) shall not be treated as eligibility for
18 other minimum essential coverage for purposes
19 of subsection (c)(2)(B) of such section 36B.
20 The Secretary shall determine the applicable second
21 lowest cost silver plan which shall apply to coverage
22 under this section for purposes of section 36B of
23 such Code.
24 ‘‘(3) ELIGIBILITY FOR COST-SHARING SUB25 SIDIES.—For purposes of applying section 1402 of

1 the Patient Protection and Affordable Care Act (42

2 U.S.C. 18071)—

3 ‘‘(A) coverage provided under this section

4 shall be treated as coverage under a qualified

5 health plan in the silver level of coverage in the

6 individual market offered through an Exchange;

7 and

8 ‘‘(B) the Secretary shall be treated as the

9 issuer of such plan.

10 ‘‘(g) NO EFFECT ON BENEFITS FOR INDIVIDUALS

11 OTHERWISE ELIGIBLE OR ON TRUST FUNDS.—The Sec12 retary shall implement the provisions of this section in

13 such a manner to ensure that such provisions—

14 ‘‘(1) have no effect on the benefits under this

15 title for individuals who are entitled to, or enrolled

16 for, such benefits other than through this section;

17 and

18 ‘‘(2) have no negative impact on the Federal

19 Hospital **Insurance** Trust Fund or the Federal Sup

20 plementary Medical **Insurance** Trust Fund (include

21 ing the Medicare Prescription Drug Account within

22 such Trust Fund).

23 ‘‘(h) CONSULTATION.—In promulgating regulations

24 to implement this section, the Secretary shall consult with

25 interested parties, including groups representing bene-

1 ficiaries, health care providers, employers, and insurance

2 companies.’’.

3 SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI4 TION PLAN.

5 (a) IN GENERAL.—To carry out the purpose of this

6 section, for plan years beginning with the first plan year

7 that begins after the date of enactment of this Act and

8 ending with the effective date described in section 106,

9 the Secretary, acting through the Administrator of the

10 Centers for Medicare & Medicaid (referred to in this sec11 tion as the ‘‘Administrator’’), shall establish, and provide

12 for the offering through the Exchanges, of a public health

13 plan (in this Act referred to as the ‘‘Medicare Transition

14 plan’’) that provides affordable, high-quality health bene15 fits coverage throughout the United States.

16 (b) ADMINISTRATING THE MEDICARE TRANSI17 TION.—

18 (1) ADMINISTRATOR.—The Administrator shall

19 administer the Medicare Transition plan in accord20 ance with this section.

21 (2) APPLICATION OF ACA REQUIREMENTS.—

22 Consistent with this section, the Medicare Transition

23 plan shall comply with requirements under title I of

24 the Patient Protection and Affordable Care Act (and

25 the amendments made by that title) and title XXVII

1 of the Public Health Service Act (42 U.S.C. 300gg

2 et seq.) that are applicable to qualified health plans

3 offered through the Exchanges, subject to the limita4 tion under subsection (e)(2).

5 (3) OFFERING THROUGH EXCHANGES.—The

6 Medicare Transition plan shall be made available

7 only through the Exchanges, and shall be available

8 to individuals wishing to enroll and to qualified em9 ployers (as defined in section 1312(f)(2) of the Pa10 tient Protection and Affordable Care Act (42 U.S.C.

11 18032)) who wish to make such plan available to

12 their employees.

13 (4) ELIGIBILITY TO PURCHASE.—Any United

14 States resident may enroll in the Medicare Transi15 tion plan.

16 (c) BENEFITS; ACTUARIAL VALUE.—In carrying out

17 this section, the Administrator shall ensure that the Medi18 care Transition plan provides—

19 (1) coverage for the benefits required to be cov20 ered under title II; and

21 (2) coverage of benefits that are actuarially

22 equivalent to 90 percent of the full actuarial value

23 of the benefits provided under the plan.

24 (d) PROVIDERS AND REIMBURSEMENT RATES.—

1 (1) IN GENERAL.—With respect to the reim2 bursement provided to health care providers for cov3 ered benefits, as described in section 201, provided

4 under the Medicare Transition plan, the Adminis5 trator shall reimburse such providers at rates deter6 mined for equivalent items and services under the

7 original Medicare fee-for-service program under

8 parts A and B of title XVIII of the Social Security

9 Act (42 U.S.C. 1395c et seq.). For items and serv10 ices covered under the Medicare Transition plan but

11 not covered under such parts A and B, the Adminis12 trator shall reimburse providers at rates set by the

13 Administrator in a manner consistent with the man14 ner in which rates for other items and services were

15 set under the original Medicare fee-for-service pro16 gram.

17 (2) PRESCRIPTION DRUGS.—Any payment rate

18 under this subsection for a prescription drug shall be

19 at a rate negotiated by the Administrator with the

20 manufacturer of the drug. If the Administrator is

21 unable to reach a negotiated agreement on such a

22 reimbursement rate, the Administrator shall estab23 lish the rate at an amount equal to the lesser of—

24 (A) the price paid by the Secretary of Vet25 erans Affairs to procure the drug under the

1 laws administered by the Secretary of Veterans

2 Affairs;

3 (B) the price paid to procure the drug

4 under section 8126 of title 38, United States

5 Code; or

6 (C) the best price determined under sec7 tion 1927(c)(1)(C) of the Social Security Act

8 (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

9 (3) PARTICIPATING PROVIDERS.—

10 (A) IN GENERAL.—A health care provider

11 that is a participating provider of services or

12 supplier under the Medicare program under

13 title XVIII of the Social Security Act (42

14 U.S.C. 1395 et seq.) or under a State Medicaid

15 plan under title XIX of such Act (42 U.S.C.

16 1396 et seq.) on the date of enactment of this

17 Act shall be a participating provider in the

18 Medicare Transition plan.

19 (B) ADDITIONAL PROVIDERS.—The Ad20 ministrator shall establish a process to allow

21 health care providers not described in subpara22 graph (A) to become participating providers in

23 the Medicare Transition plan. Such process

24 shall be similar to the process applied to new

25 providers under the Medicare program.

(e) PREMIUMS.—

(1) DETERMINATION.—The Administrator shall

determine the premium amount for enrolling in the

Medicare Transition plan, which—

(A) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section

2701(a)(1)(A) of the Public Health Service Act

(42 U.S.C. 300gg(a)(1)(A))); and

(B) shall take into account the cost-sharing reductions and premium tax credits which

will be available with respect to the plan under

section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986,

as amended by subsection (g).

(2) LIMITATION.—Variation in premium rates

of the Medicare Transition plan by rating area, as

described in clause (ii) of section 2701(a)(1)(A)(iii)

of the Public Health Service Act (42 U.S.C.

300gg(a)(1)(A)) is not permitted.

(f) TERMINATION.—This section shall cease to have

force or effect on the effective date described in section

106.

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

1 (1) PREMIUM ASSISTANCE TAX CREDITS.—

2 (A) CREDITS ALLOWED TO MEDICARE

3 TRANSITION PLAN ENROLLEES AT OR ABOVE 44

4 PERCENT OF POVERTY IN NON-EXPANSION

5 STATES.—Paragraph (1) of section 36B(c) of

6 the Internal Revenue Code of 1986 is amended

7 by redesignating subparagraphs (C) and (D) as

8 subparagraphs (D) and (E), respectively, and

9 by inserting after subparagraph (B) the fol10 lowing new subparagraph:

11 ''(C) SPECIAL RULES FOR MEDICARE

12 TRANSITION PLAN ENROLLEES.—

13 ''(i) IN GENERAL.—In the case of a

14 taxpayer who is covered, or whose spouse

15 or dependent (as defined in section 152) is

16 covered, by the Medicare Transition plan

17 established under section 1002(a) of the

18 Medicare for All Act of 2019 for all

19 months in the taxable year, subparagraph

20 (A) shall be applied without regard to 'but

21 does not exceed 400 percent'.

22 ''(ii) ENROLLEES IN MEDICAID NON23 EXPANSION STATES.—In the case of a tax24 payer residing in a State which (as of the

25 date of the enactment of the Medicare for

1 All Act of 2019) does not provide for eligi2 bility under clause (i)(VIII) or (ii)(XX) of
3 section 1902(a)(10)(A) of the Social Secu4 rity Act for medical assistance under title
5 XIX of such Act (or a waiver of the State
6 plan approved under section 1115) who is
7 covered, or whose spouse or dependent (as
8 defined in section 152) is covered, by the
9 Medicare Transition plan established under
10 section 1002(a) of the Medicare for All Act
11 of 2019 for all months in the taxable year,
12 subparagraphs (A) and (B) shall be ap13 plied by substituting ‘0 percent’ for ‘100
14 percent’ each place it appears.’’.
15 (B) PREMIUM ASSISTANCE AMOUNTS FOR
16 TAXPAYERS ENROLLED IN MEDICARE TRANSI17 TION PLAN.—
18 (i) IN GENERAL.—Subparagraph (A)
19 of section 36B(b)(3) of such Code is
20 amended—
21 (I) by redesignating clause (ii) as
22 clause (iii),
23 (II) by striking ‘‘clause (ii)’’ in
24 clause (i) and inserting ‘‘clauses (ii)
25 and (iii)’’, and

1 (III) by inserting after clause (i)

2 the following new clause:

3 ‘‘(ii) SPECIAL RULES FOR TAXPAYERS

4 ENROLLED IN MEDICARE TRANSITION

5 PLAN.—In the case of a taxpayer who is

6 covered, or whose spouse or dependent (as

7 defined in section 152) is covered, by the

8 Medicare Transition plan established under

9 section 1002(a) of the Medicare for All Act

10 of 2019 for all months in the taxable year,

11 the applicable percentage for any taxable

12 year shall be determined in the same man13 ner as under clause (i), except that the fol14 lowing table shall apply in lieu of the table

15 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% 2% 2%

100% up to 138% 2.04% 2.04%

138% up to 150% 3.06% 4.08%

150% and above 4.08% 5%.’’.

16 (ii) CONFORMING AMENDMENT.—Sub17 clause (I) of clause (iii) of section

18 36B(b)(3) of such Code, as redesignated

19 by subparagraph (A)(i), is amended by in20 serting ‘‘, and determined after the appli-

1 cation of clause (ii)'' after ''after applica2 tion of this clause''.

3 (2) COST-SHARING SUBSIDIES.—Subsection (b)

4 of section 1402 of the Patient Protection and Af5 fordable Care Act (42 U.S.C. 18071(b)) is amend6 ed—

7 (A) by inserting '', or in the Medicare

8 Transition plan established under section

9 1002(a) of the Medicare for All Act of 2019,''

10 after ''coverage'' in paragraph (1);

11 (B) by redesignating paragraphs (1) (as so

12 amended) and (2) as subparagraphs (A) and

13 (B), respectively, and by moving such subpara14 graphs 2 ems to the right;

15 (C) by striking ''INSURED.—In this sec16 tion'' and inserting ''INSURED.—

17 ''(1) IN GENERAL.—In this section'';

18 (D) by striking the flush language; and

19 (E) by adding at the end the following new

20 paragraph:

21 ''(2) SPECIAL RULES.—

22 ''(A) INDIVIDUALS LAWFULLY PRESENT.—

23 In the case of an individual described in section

24 36B(c)(1)(B) of the Internal Revenue Code of

25 1986, the individual shall be treated as having

1 household income equal to 100 percent of the
2 poverty line for a family of the size involved for
3 purposes of applying this section.
4 ‘‘(B) MEDICARE TRANSITION PLAN EN5 ROLLEES IN MEDICAID NON-EXPANSION
6 STATES.—In the case of an individual residing
7 in a State which (as of the date of the enact8 ment of the Medicare for All Act of 2019) does
9 not provide for eligibility under clause (i)(VIII)
10 or (ii)(XX) of section 1902(a)(10)(A) of the So11 cial Security Act for medical assistance under
12 title XIX of such Act (or a waiver of the State
13 plan approved under section 1115) who enrolls
14 in such Medicare Transition plan, the preceding
15 sentence, paragraph (1)(B), and paragraphs
16 (1)(A)(i) and (2)(A) of subsection (c) shall each
17 be applied by substituting ‘0 percent’ for ‘100
18 percent’ each place it appears.
19 ‘‘(C) ADJUSTED COST-SHARING FOR MEDI20 CARE TRANSITION PLAN ENROLLEES.—In the
21 case of any individual who enrolls in such Medi22 care Transition plan, in lieu of the percentages
23 under subsection (c)(1)(B)(i) and (c)(2), the
24 Secretary shall prescribe a method of deter25 mining the cost-sharing reduction for any such

1 individual such that the total of the cost-shar2 ing and the premiums paid by the individual

3 under such Medicare Transition plan does not

4 exceed the percentage of the total allowed costs

5 of benefits provided under the plan equal to the

6 final premium percentage applicable to such in7 dividual under section 36B(b)(3)(A)(ii) of the

8 Internal Revenue Code of 1986.''.

9 (h) CONFORMING AMENDMENTS.—

10 (1) TREATMENT AS A QUALIFIED HEALTH

11 PLAN.—Section 1301(a)(2) of the Patient Protection

12 and Affordable Care Act (42 U.S.C. 18021(a)(2)) is

13 amended—

14 (A) in the paragraph heading, by inserting

15 '', THE MEDICARE TRANSITION PLAN,'' before

16 ''AND''; and

17 (B) by inserting ''The Medicare Transition

18 plan,'' before ''and a multi-State plan''.

19 (2) LEVEL PLAYING FIELD.—Section 1324(a)

20 of the Patient Protection and Affordable Care Act

21 (42 U.S.C. 18044(a)) is amended by inserting ''the

22 Medicare Transition plan,'' before ''or a multi-State

23 qualified health plan''.

1 Subtitle B—Transitional Medicare

2 Reforms

3 SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF4 POCKET EXPENDITURES FOR FEE-FOR-SERV5 ICE BENEFITS AND ELIMINATION OF PARTS A

6 AND B DEDUCTIBLES.

7 (a) PROTECTION AGAINST HIGH OUT-OF-POCKET

8 EXPENDITURES.—Title XVIII of the Social Security Act

9 (42 U.S.C. 1395 et seq.), as amended by section 1001,

10 is amended by adding at the end the following new section:

11 ‘‘PROTECTION AGAINST HIGH OUT-OF-POCKET

12 EXPENDITURES

13 ‘‘SEC. 1899D. (a) IN GENERAL.—Notwithstanding

14 any other provision of this title, in the case of an indi15 vidual entitled to, or enrolled for, benefits under part A

16 or enrolled in part B, if the amount of the out-of-pocket

17 cost-sharing of such individual for a year (effective the

18 year beginning January 1 of the year following the date

19 of enactment of the Medicare for All Act of 2019) equals

20 or exceeds $1,500, the individual shall not be responsible

21 for additional out-of-pocket cost-sharing occurred during

22 that year.

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

24 ‘‘(1) IN GENERAL.—Subject to paragraphs (2)

25 and (3), in this section, the term ‘out-of-pocket cost-

1 sharing' means, with respect to an individual, the

2 amount of the expenses incurred by the individual

3 that are attributable to—

4 ''(A) **coinsurance** and copayments applica5 ble under part A or B; or

6 ''(B) for items and services that would

7 have otherwise been covered under part A or B

8 but for the exhaustion of those benefits.

9 ''(2) CERTAIN COSTS NOT INCLUDED.—

10 ''(A) NON-COVERED ITEMS AND SERV11 ICES.—Expenses incurred for items and serv12 ices which are not included (or treated as being

13 included) under part A or B shall not be con14 sidered incurred expenses for purposes of deter15 mining out-of-pocket cost-sharing under para16 graph (1).

17 ''(B) ITEMS AND SERVICES NOT FUR18 NISHED ON AN ASSIGNMENT-RELATED BASIS.—

19 If an item or service is furnished to an indi20 vidual under this title and is not furnished on

21 an assignment-related basis, any additional ex22 penses the individual incurs above the amount

23 the individual would have incurred if the item

24 or service was furnished on an assignment-re25 lated basis shall not be considered incurred ex-

1 penses for purposes of determining out-of-pock2 et cost-sharing under paragraph (1).

3 ‘‘(3) SOURCE OF PAYMENT.—For purposes of

4 paragraph (1), the Secretary shall consider expenses

5 to be incurred by the individual without regard to

6 whether the individual or another person, including

7 a State program or other third-party coverage, has

8 paid for such expenses.’’.

9 (b) ELIMINATION OF PARTS A AND B

10 DEDUCTIBLES.—

11 (1) PART A.—Section 1813(b) of the Social Se12 curity Act (42 U.S.C. 1395e(b)) is amended by add13 ing at the end the following new paragraph:

14 ‘‘(4) For each year (beginning January 1 of the year

15 following the date of enactment of the Medicare for All

16 Act of 2019), the inpatient hospital deductible for the year

17 shall be $0.’’.

18 (2) PART B.—Section 1833(b) of the Social Se19 curity Act (42 U.S.C. 1395l(b)) is amended, in the

20 first sentence—

21 (A) by striking ‘‘and for a subsequent

22 year’’ and inserting ‘‘for each of 2006 through

23 the year that includes the date of enactment of

24 the Medicare for All Act of 2019’’; and

1 (B) by inserting ‘‘, and $0 for each year

2 subsequent year’’ after ‘‘$1)’’.

3 SEC. 1012. REDUCTION IN MEDICARE PART D ANNUAL OUT4 OF-POCKET THRESHOLD AND ELIMINATION

5 OF COST-SHARING ABOVE THAT THRESHOLD.

6 (a) REDUCTION.—Section 1860D–2(b)(4)(B) of the

7 Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)) is

8 amended—

9 (1) in clause (i), by striking ‘‘For purposes’’

10 and inserting ‘‘Subject to clause (iii), for purposes’’;

11 and

12 (2) by adding at the end the following new

13 clause:

14 ‘‘(iii) REDUCTION IN THRESHOLD

15 DURING TRANSITION PERIOD.—

16 ‘‘(I) IN GENERAL.—Subject to

17 subclause (II), for plan years begin18 ning on or after January 1 following

19 the date of enactment of the Medicare

20 for All Act of 2019 and before Janu21 ary 1 of the year that is 4 years fol22 lowing such date of enactment, not23 withstanding clauses (i) and (ii), the

24 ‘annual out-of-pocket threshold’ speci-

1 fied in this subparagraph is equal to

2 $305.

3 ‘‘(II) AUTHORITY TO EXEMPT

4 BRAND-NAME DRUGS IF GENERIC

5 AVAILABLE.—In applying subclause

6 (I), the Secretary may exempt costs

7 incurred for a covered part D drug

8 that is an applicable drug under sec9 tion 1860D–14A(g)(2) if the Sec10 retary determines that a generic

11 version of that drug is available.’’.

12 (b) ELIMINATION OF COST-SHARING.—Section

13 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C.

14 1395w–102(b)(4)(A)) is amended—

15 (1) in clause (i)—

16 (A) by redesignating subclauses (I) and

17 (II) as items (aa) and (bb), respectively;

18 (B) by striking ‘‘subparagraph (B), with

19 cost-sharing’’ and inserting the following: ‘‘sub20 paragraph (B)—

21 ‘‘(I) for plan years 2006 through

22 the plan year ending December 31 fol23 lowing the date of enactment of the

24 Medicare for All Act of 2019, with

25 cost-sharing’’;

(C) in item (bb), as redesignated by sub2 paragraph (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 enact8 ment of the Medicare for All Act of 2019 and the two subsequent plan years, without any cost-sharing.’’; and

(2) in clause (ii)—

(A) by striking ‘‘clause (i)(I)’’ and insert13 ing ‘‘clause (i)(I)(aa)’’; and

(B) by adding at the end the following new sentence: ‘‘The Secretary shall continue to cal16 culate the dollar amounts specified in clause (i)(I)(aa), including with the adjustment under this clause, after plan year 2018 for purposes of 1860D–14(a)(1)(D)(iii).’’.

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

(1) in paragraph (1)—

1 (A) in subparagraph (D)(iii), by striking

2 ‘‘1860D–2(b)(4)(A)(i)(I)’’ and inserting

3 ‘‘1860D–2(b)(4)(A)(i)(I)(aa)’’; and

4 (B) in subparagraph (E)—

5 (i) in the heading, by inserting

6 ‘‘PRIOR TO THE ELIMINATION OF SUCH

7 COST-SHARING FOR ALL INDIVIDUALS’’

8 after ‘‘THRESHOLD’’; and

9 (ii) by striking ‘‘The elimination’’ and

10 inserting ‘‘For plan years 2006 through

11 the plan year ending December 31 fol12 lowing the date of enactment of the Medi13 care for All Act of 2019, the elimination’’;

14 and

15 (2) in paragraph (2)(E)—

16 (A) in the heading, by inserting ‘‘PRIOR TO

17 THE ELIMINATION OF SUCH COST-SHARING FOR

18 ALL INDIVIDUALS’’ after ‘‘THRESHOLD’’;

19 (B) by striking ‘‘Subject to’’ and inserting

20 ‘‘For plan years 2006 through the plan year

21 ending December 31 following the date of en22 actment of the Medicare for All Act of 2019,

23 subject to’’; and

24 (C) by striking ‘‘1860D–2(b)(4)(A)(i)(I)’’

25 and inserting ‘‘1860D–2(b)(4)(A)(i)(I)(aa)’’.

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

(a) DENTAL SERVICES.—

(1) REMOVAL OF EXCLUSION FROM COV6 ERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by striking para8 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 strik16 ing the period at the end and inserting ''; and''; and

(iii) by adding at the end the fol19 lowing new subparagraph:

''(II) dental services;''.

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

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

(ii) by inserting before the semicolon at the end the following: ‘‘, and (DD) with respect to dental services described in sec4 tion 1861(s)(2)(II), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).’’.

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

(b) VISION SERVICES.—

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

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

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

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

‘‘(JJ) vision services;’’.

1 (2) PAYMENT.—Section 1833(a)(1) of the So2 cial Security Act (42 U.S.C. 1395l(a)(1)), as amend3 ed by subsection (a), is amended—

4 (A) by striking ‘‘and’’ before ‘‘(DD)’’; and

5 (B) by inserting before the semicolon at

6 the end the following: ‘‘, and (EE) with respect

7 to vision services described in section

8 1861(s)(2)(JJ), the amount paid shall be an

9 amount equal to 80 percent of the lesser of the

10 actual charge for the services or the amount de11 termined under the fee schedule established

12 under section 1848(b).’’.

13 (3) EFFECTIVE DATE.—The amendments made

14 by this subsection shall apply to items and services

15 furnished on or after January 1 following the date

16 of the enactment of this Act.

17 (c) HEARING AIDS AND EXAMINATIONS THERE18 FOR.—

19 (1) IN GENERAL.—Section 1862(a)(7) of the

20 Social Security Act (42 U.S.C. 1395y(a)(7)) is

21 amended by striking ‘‘hearing aids or examinations

22 therefor,’’.

23 (2) EFFECTIVE DATE.—The amendment made

24 by this subsection shall apply to items and services

1 furnished on or after January 1 following the date

2 of the enactment of this Act.

3 SEC. 1014. ELIMINATING THE 24-MONTH WAITING PERIOD

4 FOR MEDICARE COVERAGE FOR INDIVID5 UALS WITH DISABILITIES.

6 (a) IN GENERAL.—Section 226(b) of the Social Secu7 rity Act (42 U.S.C. 426(b)) is amended—

8 (1) in paragraph (2)(A), by striking ‘‘, and has

9 for 24 calendar months been entitled to,’’;

10 (2) in paragraph (2)(B), by striking ‘‘, and has

11 been for not less than 24 months,’’;

12 (3) in paragraph (2)(C)(ii), by striking ‘‘, in13 cluding the requirement that he has been entitled to

14 the specified benefits for 24 months,’’;

15 (4) in the first sentence, by striking ‘‘for each

16 month beginning with the later of (I) July 1973 or

17 (II) the twenty-fifth month of his entitlement or sta18 tus as a qualified railroad retirement beneficiary de19 scribed in paragraph (2), and’’ and inserting ‘‘for

20 each month for which the individual meets the re21 quirements of paragraph (2), beginning with the

22 month following the month in which the individual

23 meets the requirements of such paragraph, and’’;

24 and

1 (5) in the second sentence, by striking ‘‘the

2 ‘twenty-fifth month of his entitlement’ ’’ and all that

3 follows through ‘‘paragraph (2)(C) and’’.

4 (b) CONFORMING AMENDMENTS.—

5 (1) SECTION 226.—Section 226 of the Social

6 Security Act (42 U.S.C. 426) is amended by—

7 (A) striking subsections (e)(1)(B), (f), and

8 (h); and

9 (B) redesignating subsections (g) and (i)

10 as subsections (f) and (g), respectively.

11 (2) MEDICARE DESCRIPTION.—Section 1811(2)

12 of the Social Security Act (42 U.S.C. 1395c(2)) is

13 amended by striking ‘‘have been entitled for not less

14 than 24 months’’ and inserting ‘‘are entitled’’.

15 (3) MEDICARE COVERAGE.—Section 1837(g)(1)

16 of the Social Security Act (42 U.S.C. 1395p(g)(1))

17 is amended by striking ‘‘25th month of’’ and insert18 ing ‘‘month following the first month of’’.

19 (4) RAILROAD RETIREMENT SYSTEM.—Section

20 7(d)(2)(ii) of the Railroad Retirement Act of 1974

21 (45 U.S.C. 231f(d)(2)(ii)) is amended—

22 (A) by striking ‘‘has been entitled to an

23 annuity’’ and inserting ‘‘is entitled to an annu24 ity’’;

1 (B) by striking ‘‘, for not less than 24

2 months’’; and

3 (C) by striking ‘‘could have been entitled

4 for 24 calendar months, and’’.

5 (c) EFFECTIVE DATE.—The amendments made by

6 this section shall apply to **insurance** benefits under title

7 XVIII of the Social Security Act with respect to items and

8 services furnished in months beginning after December 1

9 following the date of enactment of this Act, and before

10 January 1 of the year that is 4 years after such date of

11 enactment.

12 SEC. 1015. GUARANTEED ISSUE OF MEDIGAP POLICIES.

13 Section 1882 of the Social Security Act (42 U.S.C.

14 1395ss) is amended by adding at the end the following

15 new subsection:

16 ‘‘(aa) GUARANTEED ISSUE FOR ALL MEDIGAP-ELIGI17 BLE MEDICARE BENEFICIARIES.—
Notwithstanding para18 graphs (2)(A) and (2)(D) of subsection (s) or any other

19 provision of this section, on or after the date of enactment

20 of this subsection, the issuer of a medicare supplemental

21 policy may not deny or condition the issuance or effective22 ness of a medicare supplemental policy,
or discriminate

23 in the pricing of the policy, because of health status,

24 claims experience, receipt of health care, or medical condi25 tion in the case of any individual
entitled to, or enrolled

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

Subtitle C—Private Health Insurance Availability During Transitional Period

SEC. 1021. CONTINUITY OF CARE.

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

(b) PUBLIC CONSULTATION DURING TRANSITION.—

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

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

TITLE XI—MISCELLANEOUS

SEC. 1101. UPDATING RESOURCE LIMITS FOR SUPPLE3 MENTAL 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 Janu11 ary 1, 2019'' before the period;

(2) in subparagraph (B)—

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

(B) by inserting '', and to $4,100 on Janu16 ary 1, 2019'' before the period; and

(3) by adding at the end the following new sub18 paragraph:

''(C) Beginning with December of 2019, when20 ever 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 mul2 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 Dis10 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.

[END of TEXT]