II

115TH CONGRESS
1ST SESSION

# S. 1804

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

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IN THE SENATE OF THE UNITED STATES

SEPTEMBER 13, 2017

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

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# A BILL

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

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 2017".
6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.

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

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

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

Sec. 201. Comprehensive benefits.
Sec. 202. No cost-sharing.
Sec. 203. Exclusions and limitations.
Sec. 204. Coverage of long-term care services under Medicaid.
Sec. 205. State standards.

TITLE III—PROVIDER PARTICIPATION

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

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

Sec. 401. Administration.
Sec. 402. Consultation.
Sec. 403. Regional administration.
Sec. 404. Beneficiary ombudsman.
Sec. 405. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

Sec. 411. Application of Federal sanctions to all fraud and abuse under Universal Medicare Program.

TITLE V—QUALITY ASSESSMENT

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

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

Sec. 601. National health budget.

Subtitle B—Payments to Providers

Sec. 611. Payments to institutional and individual providers.
Sec. 612. Ensuring accurate valuation of services under the Medicare physician fee schedule.
Sec. 613. Office of primary health care.
Sec. 614. Payments for prescription drugs and approved devices and equipment.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

Sec. 701. Universal Medicare Trust Fund.

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

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

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

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

TITLE X—TRANSITION

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

Sec. 1001. Lowering the Medicare age.
Sec. 1002. Establishment of the Medicare transition plan.

Subtitle B—Transitional Medicare Reforms

Sec. 1011. Medicare protection against high out-of-pocket expenditures for fee-for-service benefits and elimination of parts A and B deductibles.
Sec. 1012. Reduction in Medicare part D annual out-of-pocket threshold and elimination of cost-sharing above that threshold.
Sec. 1013. Coverage of dental and vision services and hearing aids and examinations under Medicare part B.
Sec. 1014. Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.

TITLE XI—MISCELLANEOUS

Sec. 1101. Definitions.

# 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 may make eligible for benefits for health care services under this Act other individuals not described in subsection (a), and regulate the nature of eligibility of such individuals, while inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services.

1 **SEC. 103. FREEDOM OF CHOICE.**

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

5 **SEC. 104. NON-DISCRIMINATION.**

6 (a) IN GENERAL.—No person shall, on the basis of
7 race, color, national origin, age, disability, or sex, includ-
8 ing sex stereotyping, gender identity, sexual orientation,
9 and pregnancy and related medical conditions (including
10 termination of pregnancy), be excluded from participation
11 in, be denied the benefits of, or be subjected to discrimina-
12 tion by any participating provider as defined in section
13 301, or any entity conducting, administering, or funding
14 a health program or activity, including contracts of insur-
15 ance, pursuant to this Act.

16 (b) CLAIMS OF DISCRIMINATION.—

17 (1) IN GENERAL.—The Secretary shall establish
18 a procedure for adjudication of administrative com-
19 plaints alleging a violation of subsection (a).

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

24 (3) DAMAGES.—If the court finds a violation of
25 subsection (a), the court may grant compensatory
26 and punitive damages, declaratory relief, injunctive

1 relief, attorneys' fees and costs, or other relief as ap-
2 propriate.

3 **SEC. 105. ENROLLMENT.**

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

7 (1) include a process for the automatic enroll-
8 ment of individuals at the time of birth in the
9 United States and at the time of immigration into
10 the United States or other acquisition of qualified
11 resident status in the United States;

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

15 (3) include a process for the enrollment of indi-
16 viduals made eligible for health care services under
17 section 102(b).

18 (b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—
19 In conjunction with an individual's enrollment for benefits
20 under this Act, the Secretary shall provide for the issuance
21 of a Universal Medicare card that shall be used for pur-
22 poses of identification and processing of claims for bene-
23 fits under this program. The card shall not include an in-
24 dividual's Social Security number.

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

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

7 (b) COVERAGE FOR CHILDREN.—

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

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

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

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

1 (1) a private health insurer to sell health insur-
2 ance coverage that duplicates the benefits provided
3 under this Act; or
4 (2) an employer to provide benefits for an em-
5 ployee, former employee, or the dependents of an
6 employee or former employee that duplicate the ben-
7 efits provided under this Act.
8 (b) CONSTRUCTION.—Nothing in this Act shall be
9 construed as prohibiting the sale of health insurance cov-
10 erage for any additional benefits not covered by this Act,
11 including additional benefits that an employer may provide
12 to employees or their dependents, or to former employees
13 or their dependents.

## 14 TITLE II—COMPREHENSIVE BEN-
## 15 EFITS, INCLUDING PREVEN-
## 16 TIVE BENEFITS AND BENE-
## 17 FITS FOR LONG-TERM CARE

### 18 SEC. 201. COMPREHENSIVE BENEFITS.

19 (a) IN GENERAL.—Subject to the other provisions of
20 this title and titles IV through IX, individuals enrolled for
21 benefits under this Act are entitled to have payment made
22 by the Secretary to an eligible provider for the following
23 items and services if medically necessary or appropriate
24 for the maintenance of health or for the diagnosis, treat-
25 ment, or rehabilitation of a health condition:

1 (1) Hospital services, including inpatient and
2 outpatient hospital care, including 24-hour-a-day
3 emergency services and inpatient prescription drugs.
4 (2) Ambulatory patient services.
5 (3) Primary and preventive services, including
6 chronic disease management.
7 (4) Prescription drugs, medical devices, biologi-
8 cal products, including outpatient prescription drugs,
9 medical devices, and biological products.
10 (5) Mental health and substance abuse treat-
11 ment services, including inpatient care.
12 (6) Laboratory and diagnostic services.
13 (7) Comprehensive reproductive, maternity, and
14 newborn care.
15 (8) Pediatrics.
16 (9) Oral health, audiology, and vision services.
17 (10) Short-term rehabilitative and habilitative
18 services and devices.
19 (b) REVISION AND ADJUSTMENT.—The Secretary
20 shall, on a regular basis, evaluate whether the benefits
21 package should be improved or adjusted to promote the
22 health of beneficiaries, account for changes in medical
23 practice or new information from medical research, or re-
24 spond to other relevant developments in health science,

1 and shall make recommendations to Congress regarding
2 any such improvements or adjustments.

3 (c) COMPLEMENTARY AND INTEGRATIVE MEDI-
4 CINE.—

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

8 (A) identifying specific complementary and
9 integrative medicine practices that, on the basis
10 of research findings or promising clinical inter-
11 ventions, are appropriate to include in the bene-
12 fits package; and

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

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

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

21 (B) the Commissioner of Food and Drugs;

22 (C) institutions of higher education, pri-
23 vate research institutes, and individual re-
24 searchers with extensive experience in com-
25 plementary and alternative medicine and the in-

1 tegration of such practices into the delivery of
2 health care;
3 (D) nationally recognized providers of com-
4 plementary and integrative medicine; and
5 (E) such other officials, entities, and indi-
6 viduals with expertise on complementary and
7 integrative medicine as the Secretary deter-
8 mines appropriate.
9 (d) STATES MAY PROVIDE ADDITIONAL BENE-
10 FITS.—Individual States may provide additional benefits
11 for the residents of such States at the expense of the
12 State.

13 **SEC. 202. NO COST-SHARING.**

14 (a) IN GENERAL.—The Secretary shall ensure that
15 no cost-sharing, including deductibles, coinsurance, copay-
16 ments, or similar charges, be imposed on an individual for
17 any benefits provided under this Act, except as described
18 in subsection (b).
19 (b) EXCEPTIONS.—The Secretary may—
20 (1) impose cost-sharing with respect to services
21 provided under section 1946 of the Social Security
22 Act, as added by section 204; and
23 (2) set a cost-sharing schedule for prescription
24 drugs and biological products—
25 (A) provided that—

1 (i) such schedule is evidence-based
2 and encourages the use of generic drugs;
3 (ii) such cost-sharing does not apply
4 to preventive drugs; and
5 (iii) such cost-sharing does not exceed
6 $200 annually per individual, adjusted an-
7 nually for inflation; and
8 (B) under which the Secretary may exempt
9 brand-name drugs from consideration in deter-
10 mining whether an individual has reached any
11 out-of-pocket limit if a generic version of such
12 drug is available.
13 (c) NO BALANCE BILLING.—Notwithstanding con-
14 tracts in accordance with section 303, no provider may
15 impose a charge to an enrolled individual for covered serv-
16 ices for which benefits are provided under this Act.
17 **SEC. 203. EXCLUSIONS AND LIMITATIONS.**
18 (a) IN GENERAL.—Benefits for services are not avail-
19 able under this Act unless the services meet the standards
20 specified in section 201(a), as defined by the Secretary.
21 (b) TREATMENT OF EXPERIMENTAL SERVICES AND
22 DRUGS.—
23 (1) IN GENERAL.—In applying subsection (a),
24 the Secretary shall make national coverage deter-
25 minations with respect to services that are experi-

1 mental in nature. Such determinations shall be con-
2 sistent with the national coverage determination
3 process as defined in section 1869(f)(1)(B) of the
4 Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).
5 (2) APPEALS PROCESS.—The Secretary shall
6 establish a process by which individuals can appeal
7 coverage decisions. The process shall, as much as is
8 feasible, follow process for appeals under the Medi-
9 care program described in section 1869 of the Social
10 Security Act (42 U.S.C. 1395ff).
11 (c) APPLICATION OF PRACTICE GUIDELINES.—In the
12 case of services for which the Department of Health and
13 Human Services has recognized a national practice guide-
14 line, the services are considered to meet the standards
15 specified in section 201(a) if they have been provided in
16 accordance with such guideline. For purposes of this sub-
17 section, a service shall be considered to have been provided
18 in accordance with a practice guideline if the health care
19 provider providing the service exercised appropriate pro-
20 fessional discretion to deviate from the guideline in a man-
21 ner authorized or anticipated by the guideline.

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

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

"STATE PLAN FOR PROVIDING LONG-TERM CARE SERVICES

"SEC. 1947. (a) IN GENERAL.—For quarters beginning on or after the effective date of benefits under section 106(a) of the Medicare for All Act of 2017, notwithstanding any other provision of this title—

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

"(2) no payment to a State shall be made under this title with respect to expenditures incurred by the State in providing medical assistance after such date for services that are not long-term care services.

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

1 "(1) Nursing facility services for individuals 21
2 years of age or over described in subparagraph (A)
3 of section 1905(a)(4).
4 "(2) Home health services described in section
5 1905(a)(7).
6 "(3) Nursing services described in section
7 1905(a)(8).
8 "(4) Rehabilitative services described in section
9 1905(a)(13).
10 "(5) Inpatient services for individuals 65 years
11 of age or over provided in an institution for mental
12 disease described in section 1905(a)(14).
13 "(6) Intermediate care facility services de-
14 scribed in section 1905(a)(15).
15 "(7) Inpatient psychiatric hospital services for
16 individuals under age 21 described in section
17 1905(a)(16).
18 "(8) Case management services described in
19 section 1905(a)(19).
20 "(9) Personal care services described in section
21 1905(a)(24).
22 "(10) Nursing facility services described in sec-
23 tion 1905(a)(29).

1 "(11) Home and community-based services pro-
2 vided under a State plan amendment under section
3 1915(i).
4 "(12) Payment for self-directed personal assist-
5 ance services provided under section 1915(j).
6 "(13) Home and community-based attendant
7 services and supports provided under a State plan
8 amendment under section 1915(k).
9 "(c) MAINTENANCE OF EFFORT.—
10 "(1) ELIGIBILITY STANDARDS.—
11 "(A) IN GENERAL.—Beginning on the date
12 described in subsection (a), no payment may be
13 made under section 1903 with respect to med-
14 ical assistance provided under a State plan for
15 medical assistance if the State adopts income
16 and resource standards and methodologies for
17 purposes of determining an individual's eligi-
18 bility for medical assistance under the State
19 plan that are more restrictive than those ap-
20 plied as of May 5, 2017.
21 "(B) INDEXING OF AMOUNTS OF INCOME
22 AND RESOURCE STANDARDS.—In determining
23 whether a State has adopted income or resource
24 standards that are more restrictive than the
25 standards which applied as of May 5, 2017, the

1 Secretary shall deem the amount of any such
2 standard that was applied as of such date to be
3 increased by the percentage increase in the
4 medical care component of the consumer price
5 index for all urban consumers (U.S. city aver-
6 age) from September of 2017 to September of
7 the fiscal year for which the Secretary is mak-
8 ing such determination.
9 ''(2) EXPENDITURES.—
10 ''(A) IN GENERAL.—For each fiscal year
11 or portion of a fiscal year that occurs during
12 the period that begins on the first day of the
13 first fiscal quarter that begins on or after the
14 effective date of benefits under section 106(a)
15 of the Medicare for All Act of 2017, as a condi-
16 tion of receiving payments under section
17 1903(a), a State shall make expenditures for
18 medical assistance for services that are long-
19 term care services in an amount that is not less
20 than the expenditure floor determined for the
21 State and fiscal year (or portion of a fiscal
22 year) under subparagraph (B).
23 ''(B) EXPENDITURE FLOOR.—
24 ''(i) IN GENERAL.—For each fiscal
25 year or portion of a fiscal year described in

1 subparagraph (A), the Secretary shall de-
2 termine for each State an expenditure floor
3 that shall be equal to—
4 ''(I) the amount of the State's
5 expenditures for fiscal year 2017 on
6 medical assistance for long-term care
7 services; increased by
8 ''(II) the growth factor deter-
9 mined under subclause (ii).
10 ''(ii) GROWTH FACTOR.—For each fis-
11 cal year or portion of a fiscal year de-
12 scribed in subparagraph (A), the Secretary
13 shall, not later than September 1 of the
14 fiscal year preceding such fiscal year or
15 portion of a fiscal year, determine a
16 growth factor for each State that takes
17 into account—
18 ''(I) the percentage increase in
19 health care costs in the State;
20 ''(II) the total amount expended
21 by the State for the previous fiscal
22 year on medical assistance for long-
23 term care services;
24 ''(III) the increase, if any, in the
25 total population of the State from

1 July of 2017 to July of the fiscal year
2 preceding the fiscal year involved; and
3 ''(IV) the increase, if any, in the
4 population of individuals aged 65 and
5 older of the State from July of 2017
6 to July of the fiscal year preceding
7 the fiscal year involved.
8 ''(iii) PRORATION RULE.—Any
9 amount determined under this subpara-
10 graph for a portion of a fiscal year shall be
11 prorated based on the length of such por-
12 tion of a fiscal year relative to a complete
13 fiscal year.
14 ''(d) NONAPPLICATION OF CERTAIN REQUIRE-
15 MENTS.—Beginning on the date described in subsection
16 (a), any provision of this title requiring a State plan for
17 medical assistance to make available medical assistance
18 for services that are not long-term care services or services
19 described in section 901(a)(3)(A)(ii) of the Medicare for
20 All Act of 2017 shall have no effect.''.
21 **SEC. 205. STATE STANDARDS.**
22 (a) IN GENERAL.—Nothing in this Act shall prohibit
23 individual States from setting additional standards, with
24 respect to eligibility, benefits, and minimum provider
25 standards, consistent with the purposes of this Act, pro-

vided that such standards do not restrict eligibility or reduce access to benefits or services.

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

# TITLE III—PROVIDER PARTICIPATION

### SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.

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

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

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

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

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

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

5 (A) Services to eligible persons will be fur-
6 nished by the provider without discrimination,
7 in accordance with section 104(a). Nothing in
8 this subparagraph shall be construed as requir-
9 ing the provision of a type or class of services
10 that are outside the scope of the provider's nor-
11 mal practice.

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

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

20 (i) quality review by designated enti-
21 ties;

22 (ii) making payments under this Act,
23 including the examination of records as
24 may be necessary for the verification of in-

1 formation on which such payments are
2 based;
3 (iii) statistical or other studies re-
4 quired for the implementation of this Act;
5 and
6 (iv) such other purposes as the Sec-
7 retary may specify.
8 (D) In the case of a provider that is not
9 an individual, the provider agrees not to employ
10 or use for the provision of health services any
11 individual or other provider that has had a par-
12 ticipation agreement under this subsection ter-
13 minated for cause.
14 (E) In the case of a provider paid under
15 a fee-for-service basis, the provider agrees to
16 submit bills and any required supporting docu-
17 mentation relating to the provision of covered
18 services within 30 days after the date of pro-
19 viding such services.
20 (2) TERMINATION OF PARTICIPATION AGREE-
21 MENT.—
22 (A) IN GENERAL.—Participation agree-
23 ments may be terminated, with appropriate no-
24 tice—

1 (i) by the Secretary for failure to meet
2 the requirements of this Act; or
3 (ii) by a provider.
4 (B) TERMINATION PROCESS.—Providers
5 shall be provided notice and a reasonable oppor-
6 tunity to correct deficiencies before the Sec-
7 retary terminates an agreement unless a more
8 immediate termination is required for public
9 safety or similar reasons.
10 (C) PROVIDER PROTECTIONS.—
11 (i) PROHIBITION.—The Secretary may
12 not terminate a participation agreement or
13 in any other way discriminate against, or
14 cause to be discriminated against, any cov-
15 ered provider or authorized representative
16 of the provider, on account of such pro-
17 vider or representative—
18 (I) providing, causing to be pro-
19 vided, or being about to provide or
20 cause to be provided to the provider,
21 the Federal Government, or the attor-
22 ney general of a State information re-
23 lating to any violation of, or any act
24 or omission the provider or represent-
25 ative reasonably believes to be a viola-

1 tion of, any provision of this title (or
2 an amendment made by this title);
3 (II) testifying or being about to
4 testify in a proceeding concerning
5 such violation;
6 (III) assisting or participating, or
7 being about to assist or participate, in
8 such a proceeding; or
9 (IV) objecting to, or refusing to
10 participate in, any activity, policy,
11 practice, or assigned task that the
12 provider or representative reasonably
13 believes to be in violation of any provi-
14 sion of this Act (including any amend-
15 ment made by this Act), or any order,
16 rule, regulation, standard, or ban
17 under this Act (including any amend-
18 ment made by this Act).
19 (ii) COMPLAINT PROCEDURE.—A pro-
20 vider or representative who believes that he
21 or she has been discriminated against in
22 violation of this section may seek relief in
23 accordance with the procedures, notifica-
24 tions, burdens of proof, remedies, and stat-

utes of limitation set forth in section 2087(b) of title 15, United States Code.

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

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

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

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

(b) MINIMUM PROVIDER STANDARDS.—

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

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services and individual health care practitioners. Except as the Secretary may specify in order to carry out this Act, a hospital, skilled nursing facility, or other in-

1 stitutional provider of services shall meet standards
2 for such a provider under the Medicare program
3 under title XVIII of the Social Security Act (42
4 U.S.C. 1395 et seq.). Such standards also may in-
5 clude, where appropriate, elements relating to—
6 (A) adequacy and quality of facilities;
7 (B) training and competence of personnel
8 (including continuing education requirements);
9 (C) comprehensiveness of service;
10 (D) continuity of service;
11 (E) patient satisfaction, including waiting
12 time and access to services; and
13 (F) performance standards, including orga-
14 nization, facilities, structure of services, effi-
15 ciency of operation, and outcome in palliation,
16 improvement of health, stabilization, cure, or
17 rehabilitation.
18 (3) TRANSITION IN APPLICATION.—If the Sec-
19 retary provides for additional requirements for pro-
20 viders under this subsection, any such additional re-
21 quirement shall be implemented in a manner that
22 provides for a reasonable period during which a pre-
23 viously qualified provider is permitted to meet such
24 an additional requirement.

1 (4) ABILITY TO PROVIDE SERVICES.—With re-
2 spect to any entity or provider certified to provide
3 services described in section 201(a)(7), the Secretary
4 may not prohibit such entity or provider from par-
5 ticipating for reasons other than its ability to pro-
6 vide such services.
7 (c) FEDERAL PROVIDERS.—Any provider qualified to
8 provide health care services through the Department of
9 Veterans Affairs or Indian Health Service is a qualifying
10 provider under this section with respect to any individual
11 who qualifies for such services under applicable Federal
12 law.
13 **SEC. 303. USE OF PRIVATE CONTRACTS.**
14 (a) IN GENERAL.—Subject to the provisions of this
15 subsection, nothing in this Act shall prohibit an institu-
16 tional or individual provider from entering into a private
17 contract with an enrolled individual for any item or serv-
18 ice—
19 (1) for which no claim for payment is to be sub-
20 mitted under this Act, and
21 (2) for which the provider receives—
22 (A) no reimbursement under this Act di-
23 rectly or on a capitated basis, and
24 (B) receives no amount for such item or
25 service from an organization which receives re-

1 imbursement for such items or service under
2 this Act directly or on a capitated basis.
3 (b) BENEFICIARY PROTECTIONS.—
4 (1) IN GENERAL.—Subsection (a) shall not
5 apply to any contract unless—
6 (A) the contract is in writing and is signed
7 by the beneficiary before any item or service is
8 provided pursuant to the contract;
9 (B) the contract contains the items de-
10 scribed in paragraph (2); and
11 (C) the contract is not entered into at a
12 time when the beneficiary is facing an emer-
13 gency health care situation.
14 (2) ITEMS REQUIRED TO BE INCLUDED IN CON-
15 TRACT.—Any contract to provide items and services
16 to which subsection (a) applies shall clearly indicate
17 to the beneficiary that by signing such contract the
18 beneficiary—
19 (A) agrees not to submit a claim (or to re-
20 quest that the provider submit a claim) under
21 this Act for such items or services even if such
22 items or services are otherwise covered by this
23 Act;
24 (B) agrees to be responsible, whether
25 through insurance offered under section 107(b)

1 or otherwise, for payment of such items or serv-
2 ices and understands that no reimbursement
3 will be provided under this Act for such items
4 or services;
5 (C) acknowledges that no limits under this
6 Act apply to amounts that may be charged for
7 such items or services;
8 (D) if the provider is a non-participating
9 provider, acknowledges that the beneficiary has
10 the right to have such items or services pro-
11 vided by other providers for whom payment
12 would be made under this Act; and
13 (E) acknowledges that the provider is pro-
14 viding services outside the scope of the program
15 under this Act.
16 (c) PROVIDER REQUIREMENTS.—
17 (1) IN GENERAL.—Subsection (a) shall not
18 apply to any contract unless an affidavit described
19 in paragraph (2) is in effect during the period any
20 item or service is to be provided pursuant to the
21 contract.
22 (2) AFFIDAVIT.—An affidavit is described in
23 this subparagraph shall—
24 (A) identify the practitioner, and be signed
25 by such practitioner;

1 (B) provide that the practitioner will not
2 submit any claim under this title for any item
3 or service provided to any beneficiary (and will
4 not receive any reimbursement or amount de-
5 scribed in paragraph (1)(B) for any such item
6 or service) during the 1-year period beginning
7 on the date the affidavit is signed; and
8 (C) be filed with the Secretary no later
9 than 10 days after the first contract to which
10 such affidavit applies is entered into.
11 (3) ENFORCEMENT.—If a physician or practi-
12 tioner signing an affidavit described in paragraph
13 (2) knowingly and willfully submits a claim under
14 this title for any item or service provided during the
15 1-year period described in paragraph (2)(B) (or re-
16 ceives any reimbursement or amount described in
17 subsection (a)(2) for any such item or service) with
18 respect to such affidavit—
19 (A) this subsection shall not apply with re-
20 spect to any items and services provided by the
21 physician or practitioner pursuant to any con-
22 tract on and after the date of such submission
23 and before the end of such period; and
24 (B) no payment shall be made under this
25 title for any item or service furnished by the

physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in subsection (a)(2) shall be made for any such item or service).

# TITLE IV—ADMINISTRATION

## Subtitle A—General Administration Provisions

### SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

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

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

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

(E) levels of funding;

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

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

1 (H) planning for capital expenditures and
2 service delivery;
3 (I) planning for health professional edu-
4 cation funding;
5 (J) encouraging States to develop regional
6 planning mechanisms; and
7 (K) any other regulations necessary to
8 carry out the purpose of this Act.
9 (2) REGULATIONS.—Regulations authorized by
10 this Act shall be issued by the Secretary in accord-
11 ance with section 553 of title 5, United States Code.
12 (b) UNIFORM REPORTING STANDARDS; ANNUAL RE-
13 PORT; STUDIES.—
14 (1) UNIFORM REPORTING STANDARDS.—
15 (A) IN GENERAL.—The Secretary shall es-
16 tablish uniform State reporting requirements
17 and national standards to ensure an adequate
18 national database containing information per-
19 taining to health services practitioners, ap-
20 proved providers, the costs of facilities and
21 practitioners providing such services, the qual-
22 ity of such services, the outcomes of such serv-
23 ices, and the equity of health among population
24 groups. Such standards shall include, to the
25 maximum extent feasible without compromising

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

1 (G) Health care utilization patterns, in-
2 cluding any changes attributable to the pro-
3 gram.
4 (H) Changes in the per-capita costs of
5 health care.
6 (I) Differences in the health status of the
7 populations of the different States, including in-
8 come and racial characteristics, and other popu-
9 lation health inequities.
10 (J) Progress on quality and outcome meas-
11 ures, and long-range plans and goals for
12 achievements in such areas.
13 (K) Necessary changes in the education of
14 health personnel.
15 (L) Plans for improving service to medi-
16 cally underserved populations.
17 (M) Transition problems as a result of im-
18 plementation of this Act.
19 (N) Opportunities for improvements under
20 this Act.
21 (3) STATISTICAL ANALYSES AND OTHER STUD-
22 IES.—The Secretary may, either directly or by con-
23 tract—

1 (A) make statistical and other studies, on
2 a nationwide, regional, State, or local basis, of
3 any aspect of the operation of this Act;
4 (B) develop and test methods of payment
5 or delivery as it may consider necessary or
6 promising for the evaluation, or for the im-
7 provement, of the operation of this Act; and
8 (C) develop methodological standards for
9 evidence-based policymaking.
10 (c) AUDITS.—
11 (1) IN GENERAL.—The Comptroller General of
12 the United States shall conduct an audit of the
13 Board every fifth fiscal year following the effective
14 date of this Act to determine the effectiveness of the
15 program in carrying out the duties under subsection
16 (a).
17 (2) REPORTS.—The Comptroller General of the
18 United States shall submit a report to Congress con-
19 cerning the results of each audit conducted under
20 this subsection.
21 **SEC. 402. CONSULTATION.**
22 The Secretary shall consult with Federal agencies,
23 Indian tribes and urban Indian health organizations, and
24 private entities, such as professional societies, national as-
25 sociations, nationally recognized associations of experts,

1 medical schools and academic health centers, consumer
2 groups, and labor and business organizations in the for-
3 mulation of guidelines, regulations, policy initiatives, and
4 information gathering to ensure the broadest and most in-
5 formed input in the administration of this Act. Nothing
6 in this Act shall prevent the Secretary from adopting
7 guidelines developed by such a private entity if, in the Sec-
8 retary's judgment, such guidelines are generally accepted
9 as reasonable and prudent and consistent with this Act.

10 **SEC. 403. REGIONAL ADMINISTRATION.**

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

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

19 (1) one regional director appointed by the Sec-
20 retary;

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

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

1 (c) REGIONAL OFFICE DUTIES.—Regional offices
2 shall be responsible for—
3 (1) providing an annual State health care needs
4 assessment report to the Secretary, after a thorough
5 examination of health needs, in consultation with
6 public health officials, clinicians, patients, and pa-
7 tient advocates;
8 (2) recommending changes in provider reim-
9 bursement or payment for delivery of health services
10 in the States within the region; and
11 (3) establishing a quality assurance mechanism
12 in the State in order to minimize both under-utiliza-
13 tion and over-utilization and to ensure that all pro-
14 viders meet high quality standards.

15 **SEC. 404. BENEFICIARY OMBUDSMAN.**

16 (a) IN GENERAL.—The Secretary shall appoint a
17 Beneficiary Ombudsman who shall have expertise and ex-
18 perience in the fields of health care and education of, and
19 assistance to, individuals entitled to benefits under this
20 Act.
21 (b) DUTIES.—The Beneficiary Ombudsman shall—
22 (1) receive complaints, grievances, and requests
23 for information submitted by individuals entitled to
24 benefits under this Act with respect to any aspect of
25 the Universal Medicare Program;

1 (2) provide assistance with respect to com-
2 plaints, grievances, and requests referred to in sub-
3 paragraph (a), including—
4 (A) assistance in collecting relevant infor-
5 mation for such individuals, to seek an appeal
6 of a decision or determination made by a re-
7 gional office or the Secretary; and
8 (B) assistance to such individuals in pre-
9 senting information under relating to cost-shar-
10 ing; and
11 (3) submit annual reports to Congress and the
12 Secretary that describe the activities of the Office
13 and that include such recommendations for improve-
14 ment in the administration of this Act as the Om-
15 budsman determines appropriate. The Ombudsman
16 shall not serve as an advocate for any increases in
17 payments or new coverage of services, but may iden-
18 tify issues and problems in payment or coverage
19 policies.

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

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

1 ters pertaining to health, the Secretary shall direct the ac-
2 tivities of the Department of Health and Human Services
3 toward contributions to the health of the people com-
4 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 MEDI- 9 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 indi-
15 viduals and entities).

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

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

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

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

# 22 TITLE V—QUALITY ASSESSMENT

### 23 SEC. 501. QUALITY STANDARDS.

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

1 Clinical Standards and Quality of the Centers for Medi-
2 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 per-
7 form the following duties:

8 (1) PRACTICE GUIDELINES.—The Center shall
9 review and evaluate each practice guideline devel-
10 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 as-
22 sessing or reviewing the quality of services provided
23 by health care institutions or health care profes-
24 sionals. In evaluating such standards, the Center
25 shall consider the evidentiary basis for the standard,

1 and the validity, reliability, and feasibility of meas-
2 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 identi-
7 fying and notifying outliers.
8 (4) CRITERIA FOR ENTITIES CONDUCTING
9 QUALITY REVIEWS.—The Center shall develop min-
10 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 adminis-
14 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 review-
17 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-

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

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

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

(1) Protecting patient privacy.

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

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

(b) REPORTS TO CONGRESS.—

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

1 a report on the evaluation conducted under sub-
2 section (a). Such report shall, taking into consider-
3 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, geog-
8 raphy, or socioeconomic status under the Uni-
9 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 socio-
14 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 improv-
20 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-

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

# TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

## Subtitle A—Budgeting

### SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

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

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

(A) Quality assessment activities under title V.

(B) Health professional education expenditures.

(C) Administrative costs.

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

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

(F) Capital expenditures.

(G) Prevention and public health activities.

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

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

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

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

1 become available as described in section 106(a), up
2 to 1 percent of the budget may be allocated to pro-
3 grams providing assistance to workers who perform
4 functions in the administration of the health insur-
5 ance system and who may experience economic dis-
6 location as a result of the implementation of this
7 Act.

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

12 (b) DEFINITIONS.—In this section:

13 (1) CAPITAL EXPENDITURES.—The term ''cap-
14 ital expenditures'' means expenses for the purchase,
15 lease, construction, or renovation of capital facilities
16 and for equipment and includes return on equity
17 capital.

18 (2) HEALTH PROFESSIONAL EDUCATION EX-
19 PENDITURES.—The term ''health professional edu-
20 cation expenditures'' means expenditures in hospitals
21 and other health care facilities to cover costs associ-
22 ated with teaching and related research activities.

## Subtitle B—Payments to Providers

### SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL PROVIDERS.

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

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

1 **SEC. 612. ENSURING ACCURATE VALUATION OF SERVICES**
2 **UNDER THE MEDICARE PHYSICIAN FEE**
3 **SCHEDULE.**

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

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

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

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

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

1 U.S.C. 1305w–4(c)(2)(M)) is amended by adding at the
2 end the following new clause:
3 "(x) PLANNED AND DOCUMENTED
4 USE OF FUNDS.—For each fiscal year (be-
5 ginning with the first fiscal year beginning
6 on or after the date of enactment of this
7 clause), the Secretary shall provide to Con-
8 gress a written plan for using the funds
9 provided under clause (ix) to collect and
10 use information on physicians' services in
11 the determination of relative values under
12 this subparagraph.".
13 (c) INTERNAL TRACKING OF REVIEWS.—
14 (1) IN GENERAL.—Not later than one year
15 after the date of enactment of this Act, the Sec-
16 retary shall submit to Congress a proposed plan for
17 systematically and internally tracking 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 inter-
25 nally track the following:

1 (A) When, how, and by whom services are
2 identified for review.
3 (B) When services are reviewed or re-
4 viewed or when new services are added.
5 (C) The resources, evidence, data, and rec-
6 ommendations used in reviews.
7 (D) When relative values are adjusted.
8 (E) The rationale for final relative value
9 decisions.
10 (d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of
11 the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is
12 amended—
13 (1) in subparagraph (B)(i), by striking ''5'' and
14 inserting ''4''; and
15 (2) in subparagraph (K)(i)(I), by striking ''peri-
16 odically'' and inserting ''annually''.
17 (e) CONSULTATION WITH MEDICARE PAYMENT AD-
18 VISORY COMMISSION.—
19 (1) IN GENERAL.—Section 1848(c)(2) of the
20 Social Security Act (42 U.S.C. 1395w–4(c)(2)) is
21 amended—
22 (A) in subparagraph (B)(i), by inserting
23 ''in consultation with the Medicare Payment
24 Advisory Commission,'' after ''The Secretary,'';
25 and

1 (B) in subparagraph (K)(i)(I), as amended
2 by subsection (d)(2), by inserting "in coordina-
3 tion with the Medicare Payment Advisory Com-
4 mission," after "years,".
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 sys-
12 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 sen-
17 tence, by inserting "or the Ranking Minority
18 Member" after "the Chairman".
19 (f) PERIODIC AUDIT BY THE COMPTROLLER GEN-
20 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 subpara-
23 graph:
24 "(Q) PERIODIC AUDIT BY THE COMP-
25 TROLLER GENERAL.—

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

8 "(ii) ACCESS TO INFORMATION.—The
9 Comptroller General shall have unre-
10 stricted access to all deliberations, records,
11 and nonproprietary data related to the ac-
12 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 Admin-
19 istration, and other offices in the Department as nec-
20 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 practi-
7 tioners, registered nurses, midlevel practitioners, and
8 dentists; and
9 (4) recommend the appropriate training, edu-
10 cation, technical assistance, and patient advocacy en-
11 hancements of primary care health professionals, in-
12 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 ac-
17 cess to high quality primary health care, particularly in
18 underserved areas and for underserved populations.

19 **SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND AP-**
20 **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 discour-
4 age the use of ineffective, dangerous, or excessively
5 costly medications when better alternatives are avail-
6 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 pharma-
15 ceuticals or to remove ineffective or dangerous medi-
16 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 pa-
20 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

1 to be known as the Universal Medicare Trust Fund (in
2 this section referred to as the ''Trust Fund''). The Trust
3 Fund shall consist of such gifts and bequests as may be
4 made and such amounts as may be deposited in, or appro-
5 priated to, such Trust Fund as provided in this Act.

6 (b) APPROPRIATIONS INTO TRUST FUND.—

7 (1) TAXES.—There are hereby appropriated to
8 the Trust Fund for each fiscal year beginning with
9 the fiscal year which includes the date on which ben-
10 efits first become available as described in section
11 106, out of any moneys in the Treasury not other-
12 wise appropriated, amounts equivalent to 100 per-
13 cent of the net increase in revenues to the Treasury
14 which is attributable to the amendments made by
15 sections 801 and 902. The amounts appropriated by
16 the preceding sentence shall be transferred from
17 time to time (but not less frequently than monthly)
18 from the general fund in the Treasury to the Trust
19 Fund, such amounts to be determined on the basis
20 of estimates by the Secretary of the Treasury of the
21 taxes paid to or deposited into the Treasury; and
22 proper adjustments shall be made in amounts subse-
23 quently transferred to the extent prior estimates
24 were in excess of or were less than the amounts that
25 should have been so transferred.

1 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
2 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 appro-
7 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 Bene-
15 fits program, under chapter 89 of title 5,
16 United States Code.
17 (D) The TRICARE program, under chap-
18 ter 55 of title 10, United States Code.
19 (E) The maternal and child health pro-
20 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 Sec-
2 retary of the Treasury, to the extent the pro-
3 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 enact-
8 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 pro-
15 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 EM- 6 PLOYEE RETIREMENT IN- 7 COME SECURITY ACT OF 1974

### 8 SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA- 9 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 DUPLI- 17 CATIVE OF UNIVERSAL MEDICARE PROGRAM 18 BENEFITS; COORDINATION IN CASE OF 19 WORKERS' COMPENSATION.**

20 ''(a) IN GENERAL.—Subject to subsection (b), no em-
21 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 2017.

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 Uni-
2 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
7 one or more employers and includes an employer or
8 fund that is financially at risk for the provision of
9 workers 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 com-
19 pensation medical benefits and includes items and
20 services (including rehabilitation services and long-
21 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 Medi-
3 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 REQUIRE-**
8 **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), re-
20 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,’’.

1 (3) Section 514(b) of such Act (29 U.S.C.
2 1144(b)) is amended—
3 (A) in paragraph (7), by striking ''section
4 206(d)(3)(B)(i)).''; and
5 (B) by striking paragraph (8).
6 (4) The table of contents in section 1 of the
7 Employee Retirement Income Security Act of 1974
8 is amended by striking the items relating to part 6
9 of subtitle B of title I of such Act.

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

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

# 13 TITLE IX—ADDITIONAL 14 CONFORMING AMENDMENTS

15 **SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH**
16 **PROGRAMS.**

17 (a) MEDICARE, MEDICAID, AND STATE CHILDREN'S
18 HEALTH INSURANCE PROGRAM (SCHIP).—
19 (1) IN GENERAL.—Notwithstanding any other
20 provision of law, subject to paragraphs (2) and
21 (3)—
22 (A) no benefits shall be available under
23 title XVIII of the Social Security Act for any
24 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 as-
4 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 as-
8 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 fur-
15 nished on or after such date.
16 (2) TRANSITION.—In the case of inpatient hos-
17 pital services and extended care services during a
18 continuous period of stay which began before the ef-
19 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-

1 ices shall provide for continuation of benefits under
2 such title or plan until the end of the period of stay.
3 (3) SERVICES UNDER MEDICAID.—
4 (A) IN GENERAL.—This subsection shall
5 not apply to entitlement to medical assistance
6 provided under title XIX of the Social Security
7 Act for—
8 (i) long-term care services (as defined
9 in section 1947(b) of such Act); or
10 (ii) any other service for which bene-
11 fits are not available under this Act and
12 which is furnished under a State plan
13 under title XIX of the Social Security Act
14 which provided for medical assistance for
15 such service on September 1, 2017.
16 (B) COORDINATION BETWEEN SECRETARY
17 AND STATES.—The Secretary shall coordinate
18 with the directors of State agencies responsible
19 for administering State plans under title XIX
20 of the Social Security Act to—
21 (i) identify services described in sub-
22 paragraph (A)(ii) with respect to each
23 State plan; and
24 (ii) ensure that such services continue
25 to be made available under such plan.

1 (C) MAINTENANCE OF EFFORT REQUIRE-
2 MENT.—With respect to any service described
3 in subparagraph (A)(ii) that is made available
4 under a State plan under title XIX of the So-
5 cial Security Act, the maintenance of effort re-
6 quirements described in section 1947(c) of such
7 Act (related to eligibility standards and re-
8 quired expenditures) shall apply to such service
9 in the same manner that such requirements
10 apply to long-term care services (as defined in
11 section 1947(b) of such Act).
12 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
13 GRAM.—No benefits shall be made available under chapter
14 89 of title 5, United States Code, for any part of a cov-
15 erage period occurring on or after the effective date.
16 (c) TRICARE.—No benefits shall be made available
17 under sections 1079 and 1086 of title 10, United States
18 Code, for items or services furnished on or after the effec-
19 tive date.
20 (d) TREATMENT OF BENEFITS FOR VETERANS AND
21 NATIVE AMERICANS.—
22 (1) IN GENERAL.—Nothing in this Act shall af-
23 fect the eligibility of veterans for the medical bene-
24 fits and services provided under title 38, United
25 States Code, or of Indians for the medical benefits

1 and services provided by or through the Indian
2 Health Service.
3 (2) REEVALUATION.—No reevaluation of the
4 Indian Health Service shall be undertaken without
5 consultation with tribal leaders and stakeholders.

6 **SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE**
7 **EXCHANGES.**

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

# 16 TITLE X—TRANSITION

## 17 Subtitle A—Transitional Medicare
## 18 Buy-In Option and Transitional
## 19 Public Option

20 **SEC. 1001. LOWERING THE MEDICARE AGE.**

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

24 "TRANSITIONAL MEDICARE BUY-IN OPTION FOR CERTAIN
25 INDIVIDUALS

26 "SEC. 1899C. (a) OPTION.—

1 "(1) IN GENERAL.—Every individual who meets
2 the requirements described in paragraph (3) shall be
3 eligible to enroll under this section.
4 "(2) PARTS A, B, AND D BENEFITS.—An indi-
5 vidual enrolled under this section is entitled to the
6 same benefits (and shall receive the same protec-
7 tions) under this title as an individual who is enti-
8 tled to benefits under part A and enrolled under
9 parts B and D, including the ability to enroll in a
10 Medicare Advantage plan that provides qualified pre-
11 scription drug coverage (an MA–PD plan).
12 "(3) REQUIREMENTS FOR ELIGIBILITY.—The
13 requirements described in this paragraph are the fol-
14 lowing:
15 "(A) The individual is a resident of the
16 United States.
17 "(B) The individual is—
18 "(i) a citizen or national of the United
19 States; or
20 "(ii) an alien lawfully admitted for
21 permanent residence.
22 "(C) The individual is not otherwise enti-
23 tled to benefits under part A or eligible to en-
24 roll under part A or part B.

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

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

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

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

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

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

23 "(c) PREMIUM.—

24 "(1) AMOUNT OF MONTHLY PREMIUMS.—The Secretary shall, during September of each year (be-

1 ginning with the first September following the date
2 of enactment of the Medicare for All Act of 2017),
3 determine a monthly premium for all individuals en-
4 rolled under this section. Such monthly premium
5 shall be equal to 1⁄12 of the annual premium com-
6 puted under paragraph (2)(B), which shall apply
7 with respect to coverage provided under this section
8 for any month in the succeeding year.

9 ‘‘(2) ANNUAL PREMIUM.—

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

17 ‘‘(B) ANNUAL PREMIUM.—The annual pre-
18 mium under this subsection for months in a
19 year is equal to the average, annual per capita
20 amount estimated under subparagraph (A) for
21 the year.

22 ‘‘(3) INCREASED PREMIUM FOR CERTAIN PART
23 C AND D PLANS.—Nothing in this section shall pre-
24 clude an individual from choosing a Medicare Advan-
25 tage plan or a prescription drug plan which requires

1 the individual to pay an additional amount (because
2 of supplemental benefits or because it is a more ex-
3 pensive plan). In such case the individual would be
4 responsible for the increased monthly premium.

5 ''(d) PAYMENT OF PREMIUMS.—

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

10 ''(2) DEPOSIT.—Amounts collected by the Sec-
11 retary under this section shall be deposited in the
12 Federal Hospital Insurance Trust Fund and the
13 Federal Supplementary Medical Insurance Trust
14 Fund (including the Medicare Prescription Drug Ac-
15 count within such Trust Fund) in such proportion
16 as the Secretary determines appropriate.

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

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

24 ''(1) SATISFACTION OF INDIVIDUAL MAN-
25 DATE.—For purposes of applying section 5000A of

1 the Internal Revenue Code of 1986, the coverage
2 provided under this section constitutes minimum es-
3 sential coverage under subsection (f)(1)(A)(i) of
4 such section 5000A.

5 "(2) ELIGIBILITY FOR PREMIUM ASSISTANCE.—
6 Coverage provided under this section—

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

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

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

20 "(3) ELIGIBILITY FOR COST-SHARING SUB-
21 SIDIES.—For purposes of applying section 1402 of
22 the Patient Protection and Affordable Care Act (42
23 U.S.C. 18071)—

24 "(A) coverage provided under this section
25 shall be treated as coverage under a qualified

1 health plan in the silver level of coverage in the
2 individual market offered through an Exchange;
3 and

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

6 "(g) GUARANTEED ISSUE OF MEDIGAP POLICIES
7 UPON FIRST ENROLLMENT AND EACH SUBSEQUENT EN-
8 ROLLMENT.—In the case of an individual who enrolls
9 under this section (including an individual who was pre-
10 viously enrolled under this section), paragraphs (2)(A),
11 (2)(D), (3)(B)(ii), and (3)(B)(vi) of section 1882(s)—

12 "(1) shall be applied by substituting 'the appli-
13 cable year of age (as defined in section
14 1899C(a)(4))' for '65 years of age';

15 "(2) if the individual was enrolled under this
16 section and subsequently disenrolls, shall apply each
17 time the individual subsequently reenrolls under this
18 section as if the individual had attained the applica-
19 ble year of age (as defined in subsection (a)(4)) on
20 the date of such reenrollment (and as if the indi-
21 vidual had never previously enrolled in a Medicare
22 supplemental policy); and

23 "(3) shall be applied as if this section had not
24 been enacted (and as if the individual had never pre-

1 viously enrolled in a Medicare supplemental policy)
2 when the individual attains 65 years of age.
3 "(h) NO EFFECT ON BENEFITS FOR INDIVIDUALS
4 OTHERWISE ELIGIBLE OR ON TRUST FUNDS.—The Sec-
5 retary shall implement the provisions of this section in
6 such a manner to ensure that such provisions—
7 "(1) have no effect on the benefits under this
8 title for individuals who are entitled to, or enrolled
9 for, such benefits other than through this section;
10 and
11 "(2) have no negative impact on the Federal
12 Hospital Insurance Trust Fund or the Federal Sup-
13 plementary Medical Insurance Trust Fund (includ-
14 ing the Medicare Prescription Drug Account within
15 such Trust Fund).
16 "(i) CONSULTATION.—In promulgating regulations
17 to implement this section, the Secretary shall consult with
18 interested parties, including groups representing bene-
19 ficiaries, health care providers, employers, and insurance
20 companies.".

21 **SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSI-**
22 **TION PLAN.**

23 (a) IN GENERAL.—To carry out the purpose of this
24 section, for plan years beginning with the first plan year
25 that begins after the date of enactment of this Act and

1 ending with the effective date described in section 106,
2 the Secretary, acting through the Administrator of the
3 Centers for Medicare & Medicaid (referred to in this sec-
4 tion as the ''Administrator''), shall establish, and provide
5 for the offering through the Exchanges, of a public health
6 plan (in this Act referred to as the ''Medicare Transition
7 plan'') that provides affordable, high-quality health bene-
8 fits coverage throughout the United States.

9 (b) ADMINISTRATING THE MEDICARE TRANSI-
10 TION.—

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

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

23 (3) OFFERING THROUGH EXCHANGES.—The
24 Medicare Transition plan shall be made available
25 only through the Exchanges, and shall be available

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

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

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

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

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

17 (d) PROVIDERS AND REIMBURSEMENT RATES.—

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

1 Act (42 U.S.C. 1395c et seq.). For items and serv-
2 ices covered under the Medicare Transition plan but
3 not covered under such parts A and B, the Adminis-
4 trator shall reimburse providers at rates set by the
5 Administrator in a manner consistent with the man-
6 ner in which rates for other items and services were
7 set under the original Medicare fee-for-service pro-
8 gram.

9 (2) PRESCRIPTION DRUGS.—Any payment rate
10 under this subsection for a prescription drug shall be
11 at a rate negotiated by the Administrator with the
12 manufacturer of the drug. If the Administrator is
13 unable to reach a negotiated agreement on such a
14 reimbursement rate, the Administrator shall estab-
15 lish the rate at an amount equal to the lesser of—

16 (A) the price paid by the Secretary of Vet-
17 erans Affairs to procure the drug under the
18 laws administered by the Secretary of Veterans
19 Affairs;

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

23 (C) the best price determined under sec-
24 tion 1927(c)(1)(C) of the Social Security Act
25 (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

1 (3) PARTICIPATING PROVIDERS.—
2 (A) IN GENERAL.—A health care provider
3 that is a participating provider of services or
4 supplier under the Medicare program under
5 title XVIII of the Social Security Act (42
6 U.S.C. 1395 et seq.) or under a State Medicaid
7 plan under title XIX of such Act (42 U.S.C.
8 1396 et seq.) on the date of enactment of this
9 Act shall be a participating provider in the
10 Medicare Transition plan.
11 (B) ADDITIONAL PROVIDERS.—The Ad-
12 ministrator shall establish a process to allow
13 health care providers not described in subpara-
14 graph (A) to become participating providers in
15 the Medicare Transition plan. Such process
16 shall be similar to the process applied to new
17 providers under the Medicare program.
18 (e) PREMIUMS.—
19 (1) DETERMINATION.—The Administrator shall
20 determine the premium amount for enrolling in the
21 Medicare Transition plan, which—
22 (A) may vary according to family or indi-
23 vidual coverage, age, and tobacco status (con-
24 sistent with clauses (i), (iii), and (iv) of section

1 2701(a)(1)(A) of the Public Health Service Act
2 (42 U.S.C. 300gg(a)(1)(A))); and
3 (B) shall take into account the cost-shar-
4 ing reductions and premium tax credits which
5 will be available with respect to the plan under
6 section 1402 of the Patient Protection and Af-
7 fordable Care Act (42 U.S.C. 18071) and sec-
8 tion 36B of the Internal Revenue Code of 1986,
9 as amended by subsection (g).
10 (2) LIMITATION.—Variation in premium rates
11 of the Medicare Transition plan by rating area, as
12 described in clause (ii) of section 2701(a)(1)(A)(iii)
13 of the Public Health Service Act (42 U.S.C.
14 300gg(a)(1)(A)) is not permitted.
15 (f) TERMINATION.—This section shall cease to have
16 force or effect on the effective date described in section
17 106.
18 (g) TAX CREDITS AND COST-SHARING SUBSIDIES.—
19 (1) PREMIUM ASSISTANCE TAX CREDITS.—
20 (A) CREDITS ALLOWED TO MEDICARE
21 TRANSITION PLAN ENROLLEES AT OR ABOVE 44
22 PERCENT OF POVERTY IN NON-EXPANSION
23 STATES.—Paragraph (1) of section 36B(c) of
24 the Internal Revenue Code of 1986 is amended
25 by redesignating subparagraphs (C) and (D) as

1 subparagraphs (D) and (E), respectively, and
2 by inserting after subparagraph (B) the fol-
3 lowing new subparagraph:
4 "(C) SPECIAL RULES FOR MEDICARE
5 TRANSITION PLAN ENROLLEES.—
6 "(i) IN GENERAL.—In the case of a
7 taxpayer who is covered, or whose spouse
8 or dependent (as defined in section 152) is
9 covered, by the Medicare Transition plan
10 established under section 1002(a) of the
11 Medicare for All Act of 2017 for all
12 months in the taxable year, subparagraph
13 (A) shall be applied without regard to 'but
14 does not exceed 400 percent'.
15 "(ii) ENROLLEES IN MEDICAID NON-
16 EXPANSION STATES.—In the case of a tax-
17 payer residing in a State which (as of the
18 date of the enactment of the Medicare for
19 All Act of 2017) does not provide for eligi-
20 bility under clause (i)(VIII) or (ii)(XX) of
21 section 1902(a)(10)(A) of the Social Secu-
22 rity Act for medical assistance under title
23 XIX of such Act (or a waiver of the State
24 plan approved under section 1115) who is
25 covered, or whose spouse or dependent (as

1 defined in section 152) is covered, by the
2 Medicare Transition plan established under
3 section 1002(a) of the Medicare for All Act
4 of 2017 for all months in the taxable year,
5 subparagraphs (A) and (B) shall be ap-
6 plied by substituting '0 percent' for '100
7 percent' each place it appears.''.

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

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

14 (I) by redesignating clause (ii) as
15 clause (iii),

16 (II) by striking ''clause (ii)'' in
17 clause (i) and inserting ''clauses (ii)
18 and (iii)'', and

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

21 ''(ii) SPECIAL RULES FOR TAXPAYERS
22 ENROLLED IN MEDICARE TRANSITION
23 PLAN.—In the case of a taxpayer who is
24 covered, or whose spouse or dependent (as
25 defined in section 152) is covered, by the

1 Medicare Transition plan established under
2 section 1002(a) of the Medicare for All Act
3 of 2017 for all months in the taxable year,
4 the applicable percentage for any taxable
5 year shall be determined in the same man-
6 ner as under clause (i), except that the fol-
7 lowing table shall apply in lieu of the table
8 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%.". |

9 (ii) CONFORMING AMENDMENT.—Sub-
10 clause (I) of clause (iii) of section
11 36B(b)(3) of such Code, as redesignated
12 by subparagraph (A)(i), is amended by in-
13 serting ", and determined after the appli-
14 cation of clause (ii)" after "after applica-
15 tion of this clause".
16 (2) COST-SHARING SUBSIDIES.—Subsection (b)
17 of section 1402 of the Patient Protection and Af-
18 fordable Care Act (42 U.S.C. 18071(b)) is amend-
19 ed—

1 (A) by inserting ", or in the Medicare
2 Transition plan established under section
3 1002(a) of the Medicare for All Act of 2017,"
4 after "coverage" in paragraph (1);
5 (B) by redesignating paragraphs (1) (as so
6 amended) and (2) as subparagraphs (A) and
7 (B), respectively, and by moving such subpara-
8 graphs 2 ems to the right;
9 (C) by striking "INSURED.—In this sec-
10 tion" and inserting "INSURED.—
11 "(1) IN GENERAL.—In this section";
12 (D) by striking the flush language; and
13 (E) by adding at the end the following new
14 paragraph:
15 "(2) SPECIAL RULES.—
16 "(A) INDIVIDUALS LAWFULLY PRESENT.—
17 In the case of an individual described in section
18 36B(c)(1)(B) of the Internal Revenue Code of
19 1986, the individual shall be treated as having
20 household income equal to 100 percent of the
21 poverty line for a family of the size involved for
22 purposes of applying this section.
23 "(B) MEDICARE TRANSITION PLAN EN-
24 ROLLEES IN MEDICAID NON-EXPANSION
25 STATES.—In the case of an individual residing

1 in a State which (as of the date of the enact-
2 ment of the Medicare for All Act of 2017) does
3 not provide for eligibility under clause (i)(VIII)
4 or (ii)(XX) of section 1902(a)(10)(A) of the So-
5 cial Security Act for medical assistance under
6 title XIX of such Act (or a waiver of the State
7 plan approved under section 1115) who enrolls
8 in such Medicare Transition plan, the preceding
9 sentence, paragraph (1)(B), and paragraphs
10 (1)(A)(i) and (2)(A) of subsection (c) shall each
11 be applied by substituting '0 percent' for '100
12 percent' each place it appears.

13 ''(C) ADJUSTED COST-SHARING FOR MEDI-
14 CARE TRANSITION PLAN ENROLLEES.—In the
15 case of any individual who enrolls in such Medi-
16 care Transition plan, in lieu of the percentages
17 under subsection (c)(1)(B)(i) and (c)(2), the
18 Secretary shall prescribe a method of deter-
19 mining the cost-sharing reduction for any such
20 individual such that the total of the cost-shar-
21 ing and the premiums paid by the individual
22 under such Medicare Transition plan does not
23 exceed the percentage of the total allowed costs
24 of benefits provided under the plan equal to the
25 final premium percentage applicable to such in-

1 dividual under section 36B(b)(3)(A)(ii) of the
2 Internal Revenue Code of 1986.''.
3 (h) CONFORMING AMENDMENTS.—
4 (1) TREATMENT AS A QUALIFIED HEALTH
5 PLAN.—Section 1301(a)(2) of the Patient Protection
6 and Affordable Care Act (42 U.S.C. 18021(a)(2)) is
7 amended—
8 (A) in the paragraph heading, by inserting
9 '', THE MEDICARE TRANSITION PLAN,'' before
10 ''AND''; and
11 (B) by inserting ''The Medicare Transition
12 plan,'' before ''and a multi-State plan''.
13 (2) LEVEL PLAYING FIELD.—Section 1324(a)
14 of the Patient Protection and Affordable Care Act
15 (42 U.S.C. 18044(a)) is amended by inserting ''the
16 Medicare Transition plan,'' before ''or a multi-State
17 qualified health plan''.

## 18 Subtitle B—Transitional Medicare 19 Reforms

### 20 SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF- 21 POCKET EXPENDITURES FOR FEE-FOR-SERV- 22 ICE BENEFITS AND ELIMINATION OF PARTS A 23 AND B DEDUCTIBLES.

24 (a) PROTECTION AGAINST HIGH OUT-OF-POCKET
25 EXPENDITURES.—Title XVIII of the Social Security Act

1 (42 U.S.C. 1395 et seq.), as amended by section 1001,
2 is amended by adding at the end the following new section:
3 "PROTECTION AGAINST HIGH OUT-OF-POCKET
4 EXPENDITURES
5 "SEC. 1899D. (a) IN GENERAL.—Notwithstanding
6 any other provision of this title, in the case of an indi-
7 vidual entitled to, or enrolled for, benefits under part A
8 or enrolled in part B, if the amount of the out-of-pocket
9 cost-sharing of such individual for a year (effective the
10 year beginning January 1 of the year following the date
11 of enactment of the Medicare for All Act of 2017) equals
12 or exceeds $1,500, the individual shall not be responsible
13 for additional out-of-pocket cost-sharing occurred during
14 that year.
15 "(b) OUT-OF-POCKET COST-SHARING DEFINED.—
16 "(1) IN GENERAL.—Subject to paragraphs (2)
17 and (3), in this section, the term 'out-of-pocket cost-
18 sharing' means, with respect to an individual, the
19 amount of the expenses incurred by the individual
20 that are attributable to—
21 "(A) coinsurance and copayments applica-
22 ble under part A or B; or
23 "(B) for items and services that would
24 have otherwise been covered under part A or B
25 but for the exhaustion of those benefits.
26 "(2) CERTAIN COSTS NOT INCLUDED.—

1 "(A) NON-COVERED ITEMS AND SERV-
2 ICES.—Expenses incurred for items and serv-
3 ices which are not included (or treated as being
4 included) under part A or B shall not be con-
5 sidered incurred expenses for purposes of deter-
6 mining out-of-pocket cost-sharing under para-
7 graph (1).

8 "(B) ITEMS AND SERVICES NOT FUR-
9 NISHED ON AN ASSIGNMENT-RELATED BASIS.—
10 If an item or service is furnished to an indi-
11 vidual under this title and is not furnished on
12 an assignment-related basis, any additional ex-
13 penses the individual incurs above the amount
14 the individual would have incurred if the item
15 or service was furnished on an assignment-re-
16 lated basis shall not be considered incurred ex-
17 penses for purposes of determining out-of-pock-
18 et cost-sharing under paragraph (1).

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

1 (b) ELIMINATION OF PARTS A AND B
2 DEDUCTIBLES.—
3 (1) PART A.—Section 1813(b) of the Social Se-
4 curity Act (42 U.S.C. 1395e(b)) is amended by add-
5 ing at the end the following new paragraph:
6 "(4) For each year (beginning January 1 of the year
7 following the date of enactment of the Medicare for All
8 Act of 2017), the inpatient hospital deductible for the year
9 shall be $0.".
10 (2) PART B.—Section 1833(b) of the Social Se-
11 curity Act (42 U.S.C. 1395l(b)) is amended, in the
12 first sentence—
13 (A) by striking "and for a subsequent
14 year" and inserting "for each of 2006 through
15 the year that includes the date of enactment of
16 the Medicare for All Act of 2017"; and
17 (B) by inserting ", and $0 for each year
18 subsequent year" after "$1)".
19 **SEC. 1012. REDUCTION IN MEDICARE PART D ANNUAL OUT-**
20 **OF-POCKET THRESHOLD AND ELIMINATION**
21 **OF COST-SHARING ABOVE THAT THRESHOLD.**
22 (a) REDUCTION.—Section 1860D–2(b)(4)(B) of the
23 Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)) is
24 amended—

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

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

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

8 "(I) IN GENERAL.—Subject to
9 subclause (II), for plan years begin-
10 ning on or after January 1 following
11 the date of enactment of the Medicare
12 for All Act of 2017 and before Janu-
13 ary 1 of the year that is 4 years fol-
14 lowing such date of enactment, not-
15 withstanding clauses (i) and (ii), the
16 'annual out-of-pocket threshold' speci-
17 fied in this subparagraph is equal to
18 $305.

19 "(II) AUTHORITY TO EXEMPT
20 BRAND-NAME DRUGS IF GENERIC
21 AVAILABLE.—In applying subclause
22 (I), the Secretary may exempt costs
23 incurred for a covered part D drug
24 that is an applicable drug under sec-
25 tion 1860D–14A(g)(2) if the Sec-

1 retary determines that a generic
2 version of that drug is available.''.
3 (b) ELIMINATION OF COST-SHARING.—Section
4 1860D–2(b)(4)(A) of the Social Security Act (42 U.S.C.
5 1395w–102(b)(4)(A)) is amended—
6 (1) in clause (i)—
7 (A) by redesignating subclauses (I) and
8 (II) as items (aa) and (bb), respectively;
9 (B) by striking ''subparagraph (B), with
10 cost-sharing'' and inserting the following: ''sub-
11 paragraph (B)—
12 ''(I) for plan years 2006 through
13 the plan year ending December 31 fol-
14 lowing the date of enactment of the
15 Medicare for All Act of 2017, with
16 cost-sharing'';
17 (C) in item (bb), as redesignated by sub-
18 paragraph (A), by striking the period at the
19 end and inserting ''; and''; and
20 (D) by adding at the end the following new
21 subclause:
22 ''(II) for the plan year beginning
23 January 1 following the date of enact-
24 ment of the Medicare for All Act of

1 2017 and the two subsequent plan
2 years, without any cost-sharing.''; and
3 (2) in clause (ii)—
4 (A) by striking ''clause (i)(I)'' and insert-
5 ing ''clause (i)(I)(aa)''; and
6 (B) by adding at the end the following new
7 sentence: ''The Secretary shall continue to cal-
8 culate the dollar amounts specified in clause
9 (i)(I)(aa), including with the adjustment under
10 this clause, after plan year 2018 for purposes
11 of 1860D–14(a)(1)(D)(iii).''.
12 (c) CONFORMING AMENDMENTS TO LOW-INCOME
13 SUBSIDY.—Section 1860D–14(a) of the Social Security
14 Act (42 U.S.C. 1395w–114(a)) is amended—
15 (1) in paragraph (1)—
16 (A) in subparagraph (D)(iii), by striking
17 ''1860D–2(b)(4)(A)(i)(I)'' and inserting
18 ''1860D–2(b)(4)(A)(i)(I)(aa)''; and
19 (B) in subparagraph (E)—
20 (i) in the heading, by inserting
21 ''PRIOR TO THE ELIMINATION OF SUCH
22 COST-SHARING FOR ALL INDIVIDUALS''
23 after ''THRESHOLD''; and
24 (ii) by striking ''The elimination'' and
25 inserting ''For plan years 2006 through

1 the plan year ending December 31 fol-
2 lowing the date of enactment of the Medi-
3 care for All Act of 2017, the elimination'';
4 and
5 (2) in paragraph (2)(E)—
6 (A) in the heading, by inserting ''PRIOR TO
7 THE ELIMINATION OF SUCH COST-SHARING FOR
8 ALL INDIVIDUALS'' after ''THRESHOLD'';
9 (B) by striking ''Subject to'' and inserting
10 ''For plan years 2006 through the plan year
11 ending December 31 following the date of en-
12 actment of the Medicare for All Act of 2017,
13 subject to''; and
14 (C) by striking ''1860D–2(b)(4)(A)(i)(I)''
15 and inserting ''1860D–2(b)(4)(A)(i)(I)(aa)''.

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

19 (a) DENTAL SERVICES.—
20 (1) REMOVAL OF EXCLUSION FROM COV-
21 ERAGE.—Section 1862(a) of the Social Security Act
22 (42 U.S.C. 1395y(a)) is amended by striking para-
23 graph (12).
24 (2) COVERAGE.—

1 (A) IN GENERAL.—Section 1861(s)(2) of
2 the Social Security Act (42 U.S.C. 1395x(s)(2))
3 is amended—
4 (i) in subparagraph (FF), by striking
5 "and" at the end;
6 (ii) in subparagraph (GG), by insert-
7 ing "and" at the end; and
8 (iii) by adding at the end the fol-
9 lowing new subparagraph:
10 "(HH) dental services;".
11 (B) PAYMENT.—Section 1833(a)(1) of the
12 Social Security Act (42 U.S.C. 1395l(a)(1)) is
13 amended—
14 (i) by striking "and" before "(BB)";
15 and
16 (ii) by inserting before the semicolon
17 at the end the following: ", and (CC) with
18 respect to dental services described in sec-
19 tion 1861(s)(2)(HH), the amount paid
20 shall be an amount equal to 80 percent of
21 the lesser of the actual charge for the serv-
22 ices or the amount determined under the
23 fee schedule established under section
24 1848(b).".

1 (C) EFFECTIVE DATE.—The amendments
2 made by this subsection shall apply to items
3 and services furnished on or after January 1
4 following the date of the enactment of this Act.
5 (b) VISION SERVICES.—
6 (1) IN GENERAL.—Section 1861(s)(2) of the
7 Social Security Act (42 U.S.C. 1395x(s)(2)), as
8 amended by subsection (a), is amended—
9 (A) in subparagraph (GG), by striking
10 ''and'' at the end;
11 (B) in subparagraph (HH), by inserting
12 ''and'' at the end; and
13 (C) by adding at the end the following new
14 subparagraph:
15 ''(II) vision services;''.
16 (2) PAYMENT.—Section 1833(a)(1) of the So-
17 cial Security Act (42 U.S.C. 1395l(a)(1)), as amend-
18 ed by subsection (a), is amended—
19 (A) by striking ''and'' before ''(CC)''; and
20 (B) by inserting before the semicolon at
21 the end the following: '', and (DD) with respect
22 to vision services described in section
23 1861(s)(2)(II), the amount paid shall be an
24 amount equal to 80 percent of the lesser of the
25 actual charge for the services or the amount de-

1 termined under the fee schedule established
2 under section 1848(b).''.
3 (3) EFFECTIVE DATE.—The amendments made
4 by this subsection shall apply to items and services
5 furnished on or after January 1 following the date
6 of the enactment of this Act.
7 (c) HEARING AIDS AND EXAMINATIONS THERE-
8 FOR.—
9 (1) IN GENERAL.—Section 1862(a)(7) of the
10 Social Security Act (42 U.S.C. 1395y(a)(7)) is
11 amended by striking ''hearing aids or examinations
12 therefor,''.
13 (2) EFFECTIVE DATE.—The amendment 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 **SEC. 1014. ELIMINATING THE 24-MONTH WAITING PERIOD**
18 **FOR MEDICARE COVERAGE FOR INDIVID-**
19 **UALS WITH DISABILITIES.**
20 (a) IN GENERAL.—Section 226(b) of the Social Secu-
21 rity Act (42 U.S.C. 426(b)) is amended—
22 (1) in paragraph (2)(A), by striking '', and has
23 for 24 calendar months been entitled to,'';
24 (2) in paragraph (2)(B), by striking '', and has
25 been for not less than 24 months,'';

1 (3) in paragraph (2)(C)(ii), by striking ", in-
2 cluding the requirement that he has been entitled to
3 the specified benefits for 24 months,";
4 (4) in the first sentence, by striking "for each
5 month beginning with the later of (I) July 1973 or
6 (II) the twenty-fifth month of his entitlement or sta-
7 tus as a qualified railroad retirement beneficiary de-
8 scribed in paragraph (2), and" and inserting "for
9 each month for which the individual meets the re-
10 quirements of paragraph (2), beginning with the
11 month following the month in which the individual
12 meets the requirements of such paragraph, and";
13 and
14 (5) in the second sentence, by striking "the
15 'twenty-fifth month of his entitlement' " and all that
16 follows through "paragraph (2)(C) and".
17 (b) CONFORMING AMENDMENTS.—
18 (1) SECTION 226.—Section 226 of the Social
19 Security Act (42 U.S.C. 426) is amended by—
20 (A) striking subsections (e)(1)(B), (f), and
21 (h); and
22 (B) redesignating subsections (g) and (i)
23 as subsections (f) and (g), respectively.
24 (2) MEDICARE DESCRIPTION.—Section 1811(2)
25 of the Social Security Act (42 U.S.C. 1395c(2)) is

1 amended by striking ‘‘have been entitled for not less
2 than 24 months’’ and inserting ‘‘are entitled’’.
3 (3) MEDICARE COVERAGE.—Section 1837(g)(1)
4 of the Social Security Act (42 U.S.C. 1395p(g)(1))
5 is amended by striking ‘‘25th month of’’ and insert-
6 ing ‘‘month following the first month of’’.
7 (4) RAILROAD RETIREMENT SYSTEM.—Section
8 7(d)(2)(ii) of the Railroad Retirement Act of 1974
9 (45 U.S.C. 231f(d)(2)(ii)) is amended—
10 (A) by striking ‘‘has been entitled to an
11 annuity’’ and inserting ‘‘is entitled to an annu-
12 ity’’;
13 (B) by striking ‘‘, for not less than 24
14 months’’; and
15 (C) by striking ‘‘could have been entitled
16 for 24 calendar months, and’’.
17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to insurance benefits under title
19 XVIII of the Social Security Act with respect to items and
20 services furnished in months beginning after December 1
21 following the date of enactment of this Act, and before
22 January 1 of the year that is 4 years after such date of
23 enactment.

1 # TITLE XI—MISCELLANEOUS

2 **SEC. 1101. DEFINITIONS.**

3 In this Act—

4 (1) the term ‘‘Secretary’’ means the Secretary
5 of Health and Human Services;

6 (2) the term ‘‘State’’ means a State, the Dis-
7 trict of Columbia, or a territory of the United
8 States; and

9 (3) the term ‘‘United States’’ shall include the
10 States, the District of Columbia, and the territories
11 of the United States.

○