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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

Ms. DELAURO introduced the following bill; which was referred to the Committee on _____

A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare for America Act of 2026”.

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

Sec. 1. Short title; table of contents.

TITLE I—TRANSITIONING TO AND ESTABLISHING MEDICARE FOR AMERICA

Subtitle A—Transitional Public Health Option

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

Subtitle B—Medicare for America

- Sec. 111. Establishment and administration of medicare for america.
- Sec. 112. Modifications to and coordination with existing federal health programs.

Subtitle C—Targeted Reforms

- Sec. 121. Limitation on removal of medicare advantage providers by ma organizations.
- Sec. 122. Network adequacy.
- Sec. 123. Eliminating the 24-month waiting period for medicare coverage for individuals with disabilities.
- Sec. 124. Eliminating the waiting period for individuals on state medicaid waiting lists.
- Sec. 125. Employer health plan options.
- Sec. 126. Prohibition on step therapy and prior authorization under group health plans.
- Sec. 127. Medicare outpatient observation services.
- Sec. 128. Abortion coverage.
- Sec. 129. Applicability of mental health parity.
- Sec. 130. Student loan forgiveness for health care providers participating in medicare for america.
- Sec. 131. Clarification of the definition of pediatric medical necessity in qualifying group coverage.
- Sec. 132. Safe staffing requirements.
- Sec. 133. Enhancements for reduced cost-sharing.
- Sec. 134. Repeal of bonus payments for medicare advantage plans.

TITLE II—TAX PROVISIONS

- Sec. 201. Sunset of public laws 115–97 and 119–21.
- Sec. 202. Surtax.
- Sec. 203. Basis of property acquired from a decedent.
- Sec. 204. Medicare payroll tax.
- Sec. 205. Net investment income tax.
- Sec. 206. Termination of deduction for contributions to health savings accounts.
- Sec. 207. Increase in excise tax on small cigars and cigarettes and other tobacco products.
- Sec. 208. Excise tax on alcohol.
- Sec. 209. Tax on sugared drinks.
- Sec. 210. Repeal of excise tax on high-cost employer-sponsored health coverage.

TITLE III—DRUG-RELATED PROVISIONS

- Sec. 301. Establishment of the prescription drug and medical device review board.
- Sec. 302. Membership; staff.
- Sec. 303. Prohibition against excessive price.
- Sec. 304. Enforcement provisions.
- Sec. 305. Authority.
- Sec. 306. Regulations.
- Sec. 307. Report to federal agencies.
- Sec. 308. Definitions.
- Sec. 309. Moratorium on direct-to-consumer drug advertising.
- Sec. 310. Reporting on justification for drug price increases.

TITLE IV—OUTCOMES AND REPORTING

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

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

4 Subtitle A—Transitional Public 5 Health Option

6 SEC. 101. ESTABLISHMENT.

7 The Secretary of Health and Human Services (in this
8 subtitle referred to as the “Secretary”) shall establish a
9 public health plan option that is offered in the individual
10 market through the Federal and State Exchanges under
11 title I of the Patient Protection and Affordable Care Act
12 to eligible individuals for plan years 2028 and 2029 in
13 accordance with this subtitle.

14 SEC. 102. ELIGIBILITY.

15 Subject to subsection (b), an individual is eligible to
16 enroll in such public health plan option if the individual
17 is otherwise eligible to purchase individual health insur-
18 ance coverage through an Exchange and the individual re-

1 sides in a rating area in which the Secretary makes the
2 public health plan option available.

3 **SEC. 103. BENEFITS.**

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

8 (1) meets all requirements applicable to quali-
9 fied health plans under subtitle D of title I of the
10 Patient Protection and Affordable Care Act (other
11 than the requirement under section
12 1301(a)(1)(C)(ii) of such Act (42 U.S.C.
13 18021(a)(1)(C)(ii))) and title XXVII of the Public
14 Health Service Act;

15 (2) provides coverage of the essential health
16 benefits described in section 1302(b) of the Patient
17 Protection and Affordable Care Act (42 U.S.C.
18 18022(b));

19 (3) provides silver and gold-level coverage de-
20 scribed in section 1302(d)(1)(C) of the Patient Pro-
21 tection and Affordable Care Act (42 U.S.C.
22 18022(d)(1)(C)); and

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

1 (b) PREEMPTION.—Notwithstanding section
2 1303(a)(1) of the Patient Protection and Affordable Care
3 Act (42 U.S.C. 18023(a)(1))—

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

7 (2) no State law that would prohibit such a
8 plan from offering such coverage shall apply to such
9 plan.

10 **SEC. 104. PREMIUMS.**

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

13 (1) are adjusted based on the applicable rating
14 area;

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

16 (A) the costs of health benefits provided by
17 such plans; and

18 (B) administrative costs related to oper-
19 ating the plans;

20 (3) comply with the requirements under section
21 2701 of the Public Health Service Act (42 U.S.C.
22 300gg); and

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

1 (b) FEDERAL SUBSIDIES.—Federal subsidies shall be
2 provided to ensure that the premium shall be—

3 (1) zero in the case of an individual whose an-
4 nual household income is below 200 percent of the
5 poverty line;

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

10 (3) no individual or household above 600 per-
11 cent of poverty level will pay more than 8 percent
12 of adjusted gross monthly income toward such
13 monthly premium.

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

15 (a) IN GENERAL.—The Secretary shall establish a
16 rate schedule for reimbursing types of health care pro-
17 viders furnishing items and services under the public
18 health insurance plan option at rates based on rates ap-
19 plied for such items and services under title XVIII of the
20 Social Security Act, as of the date of the enactment of
21 this Act, that are necessary to maintain network ade-
22 quacy. The Secretary shall establish a rate schedule for
23 items and services not currently covered under title XVIII
24 of the Social Security Act, such as dental, vision, and

1 hearing benefits, well child visits, and reproductive health
2 services, at a level to ensure adequate access to providers.

3 (b) PARTICIPATING PROVIDERS.—

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

11 (2) ADDITIONAL PROVIDERS.—The Secretary
12 shall establish a process to allow health care pro-
13 viders not described in paragraph (1) to become par-
14 ticipating providers for the public health insurance
15 plan option.

16 (3) CLARIFICATION.—Notwithstanding any
17 other provision of law, health care providers may not
18 be prohibited from participating in the public health
19 insurance option for reasons other than their ability
20 to provide covered services. Health care providers
21 and institutions are prohibited from denying covered
22 individuals access to any covered benefits and serv-
23 ices because of their religious objections.

24 (c) PRESCRIPTION DRUGS.—The Secretary shall
25 apply the provisions of section 1860D–11(i) of the Social

1 Security Act (42 U.S.C. 1395w–111(i)) to prescription
2 drugs under the public health plan option in the same
3 manner as such provisions apply with respect to applicable
4 covered part D drugs under such section.

5 **SEC. 106. ACCOUNT; FUNDING.**

6 (a) ESTABLISHMENT.—There is established in the
7 Treasury of the United States an account for the receipts
8 and disbursements attributable to the operation of the
9 public health plan option.

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

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

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

1 **Subtitle B—Medicare for America**

2 **SEC. 111. ESTABLISHMENT AND ADMINISTRATION OF MEDI-**
3 **CARE FOR AMERICA.**

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

6 **“TITLE XXII—MEDICARE FOR**
7 **AMERICA**

8 **“PART A—COMPREHENSIVE HEALTH COVERAGE**

9 **“SEC. 2201. ESTABLISHMENT.**

10 “The Secretary shall establish a public health insur-
11 ance program, to be known as ‘Medicare for America’,
12 which shall for calendar year 2026 and each subsequent
13 calendar year provide comprehensive health benefits in ac-
14 cordance with this part to individuals enrolled for coverage
15 under this title.

16 **“SEC. 2202. ELIGIBILITY; AUTOMATIC ENROLLMENT.**

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

19 “(1) a resident of the United States or a terri-
20 tory of the United States;

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

24 “(3) an individual who would be eligible for cov-
25 erage under a State Medicaid plan pursuant to sec-

1 tion 1903(v) (as such section was in effect as of De-
2 cember 31, 2024), is entitled to benefits for health
3 care services under this title. The Secretary shall
4 promulgate a rule that provides criteria for applying
5 this subsection, including determining residency for
6 eligibility purposes under this title. Nothing in this
7 title shall preclude a State from using State funds
8 to provide for an individual's health coverage who is
9 not eligible under this subsection.

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

11 “(1) IN GENERAL.—Beginning in 2028, the
12 Secretary shall provide a mechanism for the enroll-
13 ment of individuals entitled to benefits under this
14 title and, in conjunction with such enrollment, the
15 issuance of a Medicare for America card which may
16 be used for purposes of identification and processing
17 of claims for benefits under this title. The card shall
18 not use the individual's social security number as an
19 identifier. As a condition of participation in the pro-
20 gram, participating providers shall facilitate enroll-
21 ment as specified by the Secretary. The State enti-
22 ties responsible for enrolling individuals in the Med-
23 icaid program under title XIX and the Children's
24 Health Insurance Program under title XXI shall

1 serve as the enrolling entity for Medicare for Amer-
2 ica within each State.

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

8 “(A) ENROLLMENT AT BIRTH.—For plan
9 years (beginning with plan year 2028), a proc-
10 ess, established by the Secretary in consultation
11 with the Commissioner of Social Security, for
12 the automatic enrollment of eligible individuals
13 born during such plan year.

14 “(B) CURRENT MEDICARE BENE-
15 FICIARIES.—

16 “(i) CURRENT MEDICARE BENE-
17 FICIARIES.—For plan years (beginning
18 with plan year 2028), a process established
19 by the Secretary for the automatic enroll-
20 ment of all individuals who are enrolled for
21 benefits under part A or B of title XVIII
22 (other than individuals who are enrolled
23 for such benefits and receiving benefits
24 under title XIX).

1 “(ii) CONTINUING POPULATION.—For
2 plan years (beginning with plan year
3 2028), a process established by the Sec-
4 retary for the automatic enrollment of eli-
5 gible individuals who attain the age of 65
6 during such plan year.

7 “(iii) DUALS.—For plan years (begin-
8 ning with plan year 2030), a process estab-
9 lished by the Secretary for the automatic
10 enrollment of eligible individuals who are
11 enrolled for benefits under part A or B of
12 title XVIII and receiving benefits under
13 title XIX.

14 “(C) OTHER INDIVIDUALS WITHOUT
15 QUALIFIED HEALTH COVERAGE.—For plan
16 years (beginning with plan year 2028), a proc-
17 ess established by the Secretary for the auto-
18 matic enrollment of eligible individuals who are
19 not enrolled in other qualified health coverage
20 (as defined in paragraph (4)(B)) for such plan
21 year.

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

1 “(A) IN GENERAL.—Enrollment periods
2 and processes for each plan year (beginning
3 with plan year 2028) for enrollment under
4 Medicare for America of any eligible individual
5 not otherwise described in paragraph (2).

6 “(B) SMALL EMPLOYERS.—

7 “(i) IN GENERAL.—For plan years
8 (beginning with plan year 2028), a process
9 and methodology under which a small em-
10 ployer, as defined in section 126(d)(3) of
11 the Medicare for America Act, may provide
12 for the enrollment of the employees of such
13 employer under Medicare for America. For
14 purposes of this subparagraph, the term
15 ‘small employer’ means any employer for
16 any calendar year if the annual payroll of
17 such employer for the preceding calendar
18 year does not exceed \$2,000,000 or has
19 fewer than 100 employees.

20 “(ii) REQUIREMENT.—Small employ-
21 ers shall either provide coverage as defined
22 within the meaning of section 2791(d)(8)
23 of the Public Health Service Act or facili-
24 tate the enrollment of their employees into
25 Medicare for America. Small employers fa-

1 cilitating enrollment into Medicare for
2 America will not be subject to a mandatory
3 employer contribution.

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

15 “(C) LARGE EMPLOYERS.—For plan years
16 (beginning with plan year 2031), the Secretary
17 shall provide for a process and methodology
18 under which a large employer may provide for
19 the enrollment of the employees of such em-
20 ployer under Medicare for America. For pur-
21 poses of the preceding sentence, the term ‘large
22 employer’ means an employer with at least 100
23 employees or whose annual payroll exceeds
24 \$2,000,000.

1 “(D) MEMBERS OF CONGRESS AND THEIR
2 STAFF.—Beginning for plan year 2028, Mem-
3 bers of Congress and their staff, subject to
4 paragraph (4), shall be enrolled in Medicare for
5 America.

6 “(4) OPT-OUT FOR INDIVIDUALS ENROLLED
7 UNDER QUALIFIED HEALTH COVERAGE.—

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

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

19 “(i) For plan years 2028 and 2029:

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

23 “(II) Medical coverage under
24 chapter 55 of title 10, United States

1 Code, including coverage under the
2 TRICARE program.

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

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

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

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

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

21 “(ii) For plan years 2030 and 2031:

22 “(I) Coverage described in sub-
23 clause (I), (II), (III), (IV), or (V) of
24 clause (i).

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

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

11 “(c) WAIVER.—The Secretary shall establish a proc-
12 ess under which the Secretary may grant waivers to States
13 for additional time (not to exceed 2 years) before popu-
14 lations described in a previous subsection of this section
15 of such State are automatically enrolled under Medicare
16 for America so long as the State can demonstrate substan-
17 tial progress has been made in transitioning these popu-
18 lations.

19 **“SEC. 2203. BENEFITS.**

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

1 “(1) Ambulatory patient services.

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

3 “(3) Hospitalization.

4 “(4) Maternity and newborn care.

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

8 “(6) Prescription drugs approved by the Food
9 and Drug Administration.

10 “(7) Rehabilitative and habilitative services and
11 devices, including the following:

12 “(A) Physical therapy.

13 “(B) Speech therapy.

14 “(C) Occupational therapy.

15 “(8) Laboratory services.

16 “(9) Preventive and wellness services and
17 chronic disease management, including the following:

18 “(A) Vaccines that, as of June 8, 2025,
19 were recommended by the Advisory Committee
20 on Immunization Policy for the Adults and
21 Child and Adolescent Immunization Schedules,
22 or were included in the Vaccines for Children
23 Program.

24 “(B) Breast cancer screening, both preven-
25 tive and additional for individuals at greater

1 risk for breast cancer, as recommended by the
2 National Comprehensive Cancer Network.

3 “(C) Any preventive service recommended
4 by the Women’s Preventive Services Initiative
5 which the United States Preventive Services
6 Task Force has not assigned a grade of A or
7 B.

8 “(10) Pediatric services, all services that would
9 otherwise be coverable under early and periodic
10 screening, diagnostic, and treatment under the Med-
11 icaid program under title XIX and services otherwise
12 included under the maternal, infant, and early child-
13 hood home visiting program under section 511, as of
14 the date of the enactment of this title.

15 “(11) Dental care, at a minimum the services
16 necessary to prevent disease and promote oral
17 health, restore oral structures to health and func-
18 tion, and treat emergency conditions, nightguards,
19 mouthguards, and dentures.

20 “(12) Hearing health services including aids
21 and exams.

22 “(13) Vision services.

23 “(14) Home- and community-based long-term
24 services and supports.

25 “(15) Chiropractic services.

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

3 “(A) Wheelchairs and accessories.

4 “(B) Walking aides such as walkers, canes,
5 and crutches.

6 “(C) Bathroom equipment such as com-
7 modes and safety equipment.

8 “(D) Inhalation therapy equipment such as
9 nebulizers.

10 “(E) Hospital beds and accessories.

11 “(F) Other devices such as Continuous
12 Positive Airway Pressure (CPAP) machines,
13 apnea monitors, and ventilators.

14 “(G) Insulin pumps and glucometers.

15 “(H) Breast pumps.

16 “(I) Lymphedema compression treatment
17 items.

18 “(J) Wigs for medical conditions.

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

21 “(L) Oxygen.

22 “(M) Orthotic and prosthetic devices.

23 “(N) Disposable medical supplies.

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

25 “(A) Reproductive health exams.

1 “(B) Patient counseling and education re-
2 lated to family planning.

3 “(C) Abortion.

4 “(D) Screening, testing, treatment, and
5 pre- and post-test counseling for sexually trans-
6 mitted diseases and HIV.

7 “(E) Contraceptives including pill, patch,
8 medication, condom, implant, or other devices
9 used to prevent pregnancy.

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

12 “(G) Infertility treatment.

13 “(18) Gender-confirming medical procedures
14 and treatment.

15 “(19) Screening, testing, treatment, and pre-
16 and post-test counseling for sexually transmitted dis-
17 eases and HIV.

18 “(20) Dietary and nutrition counseling.

19 “(21) Medically necessary food and vitamins for
20 digestive and inherited metabolic disorders.

21 “(22) Nursing facilities.

22 “(23) Acupuncture.

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

1 “(25) Telehealth.

2 “(26) Non-emergency medical transportation.

3 “(27) Care coordination, including services de-
4 fined in section 440.169 of title 42, Code of Federal
5 Regulations.

6 “(28) Palliative care.

7 “(29) Any additional benefit or service not in-
8 cluded in this section that is coverable by any State
9 plan (or waiver of such State plan) under title XIX
10 on the date of the enactment of this title.

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

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

22 “(d) PROHIBITION AGAINST DUPLICATING COV-
23 ERAGE.—

24 “(1) IN GENERAL.—It is unlawful for a private
25 health insurer (other than an insurer with respect to

1 a Medicare Advantage for America plan under part
2 C of this title or qualified employer-based coverage)
3 to sell health insurance coverage that duplicates the
4 benefits provided under Medicare for America under
5 this part.

6 “(2) CONSTRUCTION.—Nothing in paragraph
7 (1) shall be construed as prohibiting the sale of
8 health insurance coverage for any additional benefits
9 not covered by this part, insofar as the coverage sat-
10 isfies the conditions of paragraphs (3) and (4).
11 Nothing shall preclude employers meeting the re-
12 quirements under section 126 of the Medicare for
13 America Act from providing supplemental coverage
14 under this section to their employees.

15 “(3) APPLICATION OF PROTECTIONS.—For pur-
16 poses of paragraph (2), health insurance coverage
17 for any additional benefits must satisfy the following
18 conditions:

19 “(A) The provisions of section 2718 of the
20 Public Health Service Act, relating to a medical
21 loss ratio.

22 “(B) The provisions of section 2702 of the
23 Public Health Service Act, relating to guaran-
24 teed issue.

1 “(C) The provisions of section 2701 of the
2 Public Health Service Act, relating to commu-
3 nity rating.

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

7 “(4) NO FEES TO BROKERS.—For purposes of
8 paragraph (2), the condition described in this para-
9 graph is that health insurance coverage described in
10 such paragraph does not pay fees to insurance bro-
11 kers.

12 “(e) STATES MAY PROVIDE ADDITIONAL BENE-
13 FITS.—Individual States may provide additional benefits
14 for the residents of such States at the expense of the
15 State.

16 “(f) PROHIBITION AGAINST STEP THERAPY AND
17 PRIOR AUTHORIZATION.—Items and services covered
18 under Medicare for America shall be covered without any
19 need for any prior authorization determination and with-
20 out any limitation applied through the use of step therapy
21 protocols.

22 **“SEC. 2204. PREMIUMS.**

23 “(a) IN GENERAL.—

24 “(1) IN GENERAL.—Subject to paragraph (2),
25 each individual enrolled for benefits under this title

1 for a year shall pay monthly community-rated pre-
2 miums for such year in an amount determined by
3 the Secretary in accordance with subsection (b).

4 “(2) GRANDFATHERED MEDICARE BENE-
5 FICIARIES.—In the case of an individual enrolled
6 under part B of title XVIII as of the date of the en-
7 actment of this part, the premium applied under this
8 section for such individual for benefits under this
9 title shall be the lesser of—

10 “(A) the premium otherwise applicable to
11 such individual under such title XVIII if this
12 title had not been enacted; or

13 “(B) the premium that would be applied to
14 such individual under this title without the ap-
15 plication of this paragraph.

16 “(b) PREMIUM CONTRIBUTION BASED ON INCOME.—
17 The amount of a monthly premium, with respect to a plan
18 year (beginning with 2028), under this section shall be
19 established by the Secretary in accordance with the fol-
20 lowing:

21 “(1) Such premium shall be determined such
22 that the collective premiums for the plan year are
23 with respect to the costs of health benefits provided
24 under this title for such year and related administra-
25 tive costs.

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

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

5 “(A) zero in the case of an individual
6 whose annual household income is below 200
7 percent of the poverty line;

8 “(B) determined by a linear sliding scale,
9 in the case of an individual whose household in-
10 come is at least 200 percent of the poverty line,
11 but not more than 600 percent of the poverty
12 line; and

13 “(C) no individual or household will pay
14 more than 8 percent of adjusted gross monthly
15 income toward such premium.

16 “(4) For an individual whose employer will be
17 making a firm-wide contribution under this title in
18 lieu of offering employer-sponsored insurance (as
19 specified in section 126(b)(1)(B) of the Medicare for
20 America Act), such individual shall pay a premium
21 in accordance with this subsection.

22 “(5) For an individual who has opted out of
23 their employer-sponsored insurance in order to enroll
24 in Medicare for America as specified in section

1 126(c) of such Act, the individual shall pay the less-
2 er of—

3 “(A) the premium described in this sub-
4 section; or

5 “(B) the amount owed after the amount of
6 employer contribution (as specified in section
7 126(b)(1)(B) of the Medicare for America Act)
8 is subtracted from the premium established by
9 the Secretary of Health and Human Services as
10 described in paragraph (1), whichever is less.

11 “(c) DEPOSITS.—Amounts paid under this section for
12 coverage under this title shall be deposited in the Treasury
13 to the credit of the Trust Fund established under section
14 2206.

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

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

22 “(2) The Secretary, in consultation with the
23 Commissioner of Social Security, shall develop and
24 publish a formal application for requesting an action
25 of the Secretary under paragraph (1) to correct or

1 eliminate the effects of an error, misrepresentation,
2 or inaction described in such paragraph and deter-
3 mine and publish specific timelines for timely resolu-
4 tion of such a request.

5 “(3) The Secretary shall also require that all
6 such determinations with respect to such requests
7 shall be reached within 15 business days of the sub-
8 mission of such application. All determinations shall
9 be in writing through a standard decision notice
10 which shall include an explanation of the reasons for
11 the determination.

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

19 “(5) An individual who receives an adverse de-
20 termination under paragraph (3) may appeal to an
21 independent review organization designated by the
22 Commission. Any such appeal must be sent to the
23 independent review organization within 90 days of
24 the date the individual received the determination to
25 be eligible for review. The independent review orga-

1 nization shall review and reach a determination of
2 the review in writing within 45 days of the receipt
3 of any such appeal.

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

7 “(A) unless the organization has staff that
8 has the appropriate knowledge of, and experi-
9 ence with, the eligibility and coordination of
10 benefits rules and regulations under this title;
11 and

12 “(B) to the extent the organization is a fis-
13 cal intermediary under section 1816, a carrier
14 under section 1842, or a Medicare administra-
15 tive contractor under section 1874A.

16 “(7) The Secretary shall provide for access by
17 independent review organizations conducting appeal
18 determinations under this subsection, to the data-
19 base of the Coordination of Benefits Contractor of
20 the Centers for Medicare & Medicaid Services as
21 necessary in order to conduct the duties of such or-
22 ganizations to determine appeals pursuant to this
23 subsection.

1 **“SEC. 2205. PAYMENT OF BENEFITS; COST-SHARING; OUT-**
2 **OF-POCKET LIMITS.**

3 “(a) PAYMENT OF BENEFITS; COST-SHARING.—
4 There shall be paid, in the case of each individual who
5 is enrolled under Medicare for America and incurs ex-
6 penses for items and services with respect to which bene-
7 fits are payable under this part, subject to subsection (c),
8 80 percent of the reimbursement rates established pursu-
9 ant to section 2206 for such items and services, except
10 that for the following services, the amounts paid under
11 this section shall be equal to 100 percent of the reimburse-
12 ment rates established pursuant to section 2206 for such
13 items and services:

14 “(1) Preventive and chronic disease services
15 covered under paragraph (9) or (29) of section
16 2203(a).

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

18 “(3) Generic drugs, and prescription drugs if
19 medically necessary.

20 “(4) All services for individuals who are medi-
21 cally frail or otherwise have special medical needs,
22 (including children with serious emotional disturb-
23 ance and adults with serious mental illness), individ-
24 uals with chronic substance use disorders, or individ-
25 uals with serious and complex medical conditions
26 (such as epilepsy and HIV), individuals with a phys-

1 ical, intellectual or developmental disability that sig-
2 nificantly impairs their ability to perform one or
3 more activities of daily living.

4 “(5) Pregnancy-related services.

5 “(6) Emergency services.

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

7 The Secretary shall establish a default monthly payment
8 plan under the Medicare for America benefits package to
9 ensure the payment owed by the individual enrolled under
10 Medicare for America is spread-out evenly throughout the
11 year.

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

14 “(c) MAXIMUM OUT-OF-POCKET LIMIT.—

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

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

23 “(A) IN GENERAL.—For purposes of para-
24 graph (1), subject to subparagraphs (B) and
25 (C), the annual out-of-pocket threshold speci-

1 fied in this paragraph is a threshold that shall
2 be determined on a linear sliding scale for
3 household income that is at least 200 percent of
4 the poverty line, but not more than 600 percent
5 of the poverty line, and that shall not exceed—

6 “(i) with respect to an individual,
7 \$3,500; or

8 “(ii) with respect to a household,
9 \$5,000. Individuals or households with in-
10 come above 600 percent of the Federal
11 poverty line shall have their annual out-of-
12 pocket threshold capped at \$3,500 and
13 \$5,000, respectively.

14 “(B) INDEXING.—In the case of plan years
15 beginning after 2028, the threshold described in
16 subparagraph (A) (as in effect for the preceding
17 plan year after application of this subpara-
18 graph) shall be increased by the percentage in-
19 crease over the previous year in the medical
20 care expenditure category of the Consumer
21 Price Index for All Urban Consumers (United
22 States city average), published by the Bureau
23 of Labor Statistics.

24 “(C) EXCEPTION.—For purposes of para-
25 graph (1), the annual out-of-pocket threshold

1 for individuals and households with annual in-
2 come below 200 percent of the Federal poverty
3 line is \$0.

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

7 “(e) NO BALANCE BILLING.—No provider may im-
8 pose a charge to an enrolled individual for coverable serv-
9 ices for which benefits are provided under this part in an
10 amount higher than the reimbursement rate for such serv-
11 ices under section 2206 and may not impose a charge to
12 such individual for such service other than with respect
13 to the other cost-sharing described in this section.

14 “(f) NO PRIVATE CONTRACTING.—A health care pro-
15 vider or health care institution are prohibited from enter-
16 ing into a private contract with an individual enrolled
17 under Medicare for America for any item or service
18 coverable under Medicare for America.

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

1 **“SEC. 2206. PROVIDERS NETWORK AND REIMBURSEMENT**
2 **RATES.**

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

8 “(b) RATES.—

9 “(1) IN GENERAL.—Except as provided in para-
10 graphs (2) and (3), the Secretary shall establish
11 rates for benefits and services to be provided to
12 health care providers and suppliers furnishing under
13 Medicare for America based on rates that would be
14 applied (including as computed, updated, and ad-
15 justed) under title XVIII or title XIX, whichever is
16 higher, for such type of health care providers and
17 suppliers and item and service if such title remained
18 in effect and, in the case of a type of provider and
19 supplier or item or service coverable under Medicare
20 for America but not otherwise coverable under title
21 XVIII or title XIX, shall provide for rates that en-
22 sure adequate access to care.

23 “(2) EXCEPTIONS.—For purposes of this sec-
24 tion, in applying paragraph (1) the Secretary shall
25 ensure that rates to hospitals for inpatient services
26 or outpatient services furnished under Medicare for

1 America are at least 110 percent of such rates on
2 average or in the aggregate for furnishing such inpa-
3 tient or outpatient services otherwise applied under
4 title XVIII or title XIX, whichever is higher, except
5 that for hospitals serving underserved areas as speci-
6 fied by the Secretary, such rates are increased as
7 necessary to ensure adequate access to care.

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

11 “(A) The Secretary shall provide for site-
12 neutral payments for items and services fur-
13 nished in an outpatient hospital and physician
14 office, the rate of payment for such service shall
15 be the same.

16 “(B) The Secretary shall provide for a
17 mechanism to provide payments for direct and
18 indirect costs of graduate medical education
19 programs without any cap on the number of
20 residency positions for which payment may be
21 made, including payments to hospitals for such
22 programs and to eligible facilities for programs
23 for population health-based residencies and for
24 nurse practitioner post-licensure clinical train-
25 ing, residency, and fellowship programs.

1 “(C) The Secretary shall increase the aver-
2 age relative value of primary care and other
3 mental and behavioral health and cognitive
4 services by not less than 30 percent in order to
5 ensure adequate access to inpatient and out-
6 patient care.

7 “(D) As a condition of participation in the
8 program, participating providers shall accept
9 Medicare for America rates paid by employer-
10 sponsored insurance plans and Medicare Advan-
11 tage for America plans.

12 “(E) The Secretary shall semiannually re-
13 view if the rates paid by Medicare for America
14 are creating barriers to care. The Secretary
15 shall have the authority to raise rates as nec-
16 essary to ensure adequate access to care.

17 “(4) INCREASED FEDERAL MATCH
18 FORMMEDICAID AND THE CHILDREN’S HEALTH IN-
19 SURANCE PROGRAM FOR YEARS 2028 THROUGH
20 2033.—The Secretary of Health and Human Services
21 shall pay the difference between the Medicare for
22 America rates and the Medicaid and CHIP rates
23 during the period beginning on January 1, 2028,
24 and ending on December 31, 2033.

25 “(c) PARTICIPATING PROVIDERS.—

1 “(1) IN GENERAL.—A health care provider that
2 is a participating provider of services or supplier
3 under the Medicare program under title XVIII or
4 the Medicaid program under title XIX on the date
5 of enactment of this title shall remain a partici-
6 pating provider for Medicare for America.

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

11 “(d) PRESCRIPTION DRUGS.—

12 “(1) IN GENERAL.—Notwithstanding any other
13 provision of law, the Secretary shall, for plan years
14 beginning on or after the date of the enactment of
15 this title, negotiate with pharmaceutical manufactur-
16 ers the prices (including discounts, rebates, and
17 other price concessions) that may be charged to
18 Medicare for America and MA for America organiza-
19 tions during a negotiated price period (as specified
20 by the Secretary) for covered drugs for Medicare for
21 America enrollees. In negotiating such prices under
22 this section, the Secretary shall take into account
23 the following factors:

1 “(A) The comparative clinical effectiveness
2 and cost effectiveness, when available from an
3 impartial source, of such drug.

4 “(B) The budgetary impact of providing
5 coverage of such drug.

6 “(C) The number of similarly effective
7 drugs or alternative treatment regimens for
8 each approved use of such drug.

9 “(D) The associated financial burden on
10 patients that utilize such drug.

11 “(E) The associated unmet patient need
12 for such drug.

13 “(F) The total revenues from global sales
14 obtained by the manufacturer for such drug
15 and the associated investment in research and
16 development of such drug by the manufacturer.

17 “(2) FINALIZATION OF NEGOTIATED PRICE.—
18 The negotiated price of each covered drug for a ne-
19 gotiated price period shall be finalized not later than
20 30 days before the first plan year in such negotiated
21 price period.

22 “(3) COMPETITIVE LICENSING AUTHORITY.—

23 “(A) IN GENERAL.—Notwithstanding any
24 exclusivity under clause (iii) or (iv) of section
25 505(j)(5)(F) of the Federal Food, Drug, and

1 Cosmetic Act, clause (iii) or (iv) of section
2 505(c)(3)(E) of such Act, section 351(k)(7)(A)
3 of the Public Health Service Act, or section
4 527(a) of the Federal Food, Drug, and Cos-
5 metic Act, or by an extension of such exclusivity
6 under section 505A of such Act or section 505E
7 of such Act, and any other provision of law that
8 provides for market exclusivity (or extension of
9 market exclusivity) with respect to a drug, in
10 the case that the Secretary is unable to success-
11 fully negotiate an appropriate price for a cov-
12 ered drug for a negotiated price period, the Sec-
13 retary shall authorize the use of any patent,
14 clinical trial data, or other exclusivity granted
15 by the Federal Government with respect to such
16 drug as the Secretary determines appropriate
17 for purposes of manufacturing such drug for
18 sale under Medicare for America. Any entity
19 making use of a competitive license to use pat-
20 ent, clinical trial data, or other exclusivity
21 under this section shall provide to the manufac-
22 turer holding such exclusivity reasonable com-
23 pensation, as determined by the Secretary
24 based on the following factors:

1 “(i) The risk-adjusted value of any
2 Federal Government subsidies and invest-
3 ments in research and development used to
4 support the development of such drug.

5 “(ii) The risk-adjusted value of any
6 investment made by such manufacturer in
7 the research and development of such
8 drug.

9 “(iii) The impact of the price, includ-
10 ing license compensation payments, on
11 meeting the medical need of all patients.

12 “(iv) The relationship between the
13 price of such drug, including compensation
14 payments, and the health benefits of such
15 drug.

16 “(v) Other relevant factors determined
17 appropriate by the Secretary to provide
18 reasonable compensation.

19 “(B) REASONABLE COMPENSATION.—The
20 manufacturer described in subparagraph (A)
21 may seek recovery against the United States in
22 the United States Court of Federal Claims.

23 “(C) INTERIM PERIOD.—

24 “(i) IN GENERAL.—Until 1 year after
25 a drug described in subparagraph (A) is

1 approved under section 505(j) of the Fed-
2 eral Food, Drug, and Cosmetic Act or sec-
3 tion 351(k) of the Public Health Service
4 Act and is provided under license issued by
5 the Secretary under such subparagraph,
6 Medicare for America shall not pay more
7 for such drug than the average of the
8 prices available, during the most recent 12-
9 month period for which data is available
10 prior to the beginning of such negotiated
11 price period, from the manufacturer to any
12 wholesaler, retailer, provider, health main-
13 tenance organization, nonprofit entity, or
14 governmental entity in the ten OECD (Or-
15 ganization for Economic Cooperation and
16 Development) countries that have the larg-
17 est gross domestic product with a per cap-
18 ita income that is not less than half the
19 per capita income of the United States or
20 the price established by the Prescription
21 Drug and Medical Device Review Board
22 established under title III of the Medicare
23 for America Act of 2019.

24 “(ii) FEDERAL PROGRAM LICENS-
25 ING.—If such drug is not made available

1 at the price determined, the Secretary shall
2 authorize such entities to use any patent,
3 clinical trial data, or other exclusivity
4 granted by the Federal Government with
5 respect to such drug as the Secretary de-
6 termines appropriate for purposes of man-
7 ufacturing such drug for sale under any
8 Federal program, including those provided
9 by Medicare for America, Veterans Affairs,
10 the Department of Defense, and the Coast
11 Guard.

12 “(D) AUTHORIZATION FOR SECRETARY TO
13 PROCURE DRUGS DIRECTLY.—

14 “(i) IN GENERAL.—The Secretary
15 may procure a drug manufactured pursu-
16 ant to a competitive license under subpara-
17 graph (A) for purposes of this part or pur-
18 suant to a Federal program license under
19 subparagraph (C)(ii) for purposes of a
20 Federal program directly from the entity
21 manufacturing the drug pursuant to such
22 a license.

23 “(ii) CLARIFICATION REGARDING AP-
24 PPLICATION OF BUY AMERICAN ACT.—In
25 the case where the Secretary procures a

1 drug under this subparagraph, the provi-
2 sions of chapter 83 of title 41, United
3 States Code (commonly referred to as the
4 ‘Buy American Act’), shall apply.

5 “(E) PRIORITY FOR U.S. MANUFACTURERS
6 IN AUTHORIZING COMPETITIVE LICENSES.—In
7 authorizing a competitive license under this
8 paragraph, the Secretary—

9 “(i) shall give preference to entities
10 that the Secretary determines have the
11 highest safety and security standards; and

12 “(ii) may give priority to entities that
13 will manufacture such drug in the United
14 States.

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

20 “(5) PROHIBITION OF ANTICOMPETITIVE BE-
21 HAVIOR.—No drug manufacturer may engage in
22 anticompetitive behavior with another manufacturer
23 that may interfere with the issuance and implemen-
24 tation of a competitive license or run contrary to
25 public policy.

1 “(6) REQUIRED REPORTING.—The Secretary
2 may require pharmaceutical manufacturers to dis-
3 close to the Secretary such information that the Sec-
4 retary determines necessary for purposes of carrying
5 out this subsection.

6 “(7) CLARIFICATION.—Nothing in this sub-
7 section shall be construed as preventing Medicare for
8 America obtaining a discount or reduction of the
9 price for a covered drug below the price negotiated
10 by the Secretary.

11 “(8) VALUE OR COST-EFFECTIVENESS ASSESS-
12 MENTS.—The use of Quality-Adjusted Life Years,
13 Disability-Adjusted Life Years, or other similar
14 mechanisms is prohibited for use in value or cost-ef-
15 fectiveness assessments for purposes of this sub-
16 section.

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

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

20 “(a) TRUST FUND.—There shall be established a uni-
21 fied Medicare Trust Fund in which funds provided under
22 this title are deposited and from which expenditures under
23 this title are made. The Trust Fund shall consist of such
24 gifts and bequests as may be made and such amounts as

1 may be deposited in, or appropriated to, such Trust Fund
2 as provided in this Act.

3 “(b) FUNDING.—

4 “(1) TAXES.—There are hereby appropriated to
5 the Trust Fund for each fiscal year beginning with
6 fiscal year 2028, out of any moneys in the Treasury
7 not otherwise appropriated, amounts equivalent to
8 100 percent of the net increase in revenues to the
9 Treasury which is attributable to the amendments
10 made by title II of the Medicare for America Act
11 and premiums collected under this title. The
12 amounts appropriated by the preceding sentence
13 shall be transferred from time to time (but not less
14 frequently than monthly) from the general fund in
15 the Treasury to the Trust Fund, such amounts to be
16 determined on the basis of estimates by the Sec-
17 retary of the Treasury of the taxes paid to or depos-
18 ited into the Treasury; and proper adjustments shall
19 be made in amounts subsequently transferred to the
20 extent prior estimates were in excess of or were less
21 than the amounts that should have been so trans-
22 ferred.

23 “(2) CURRENT PROGRAM RECEIPTS.—Notwith-
24 standing any other provision of law, there are hereby
25 appropriated to the Trust Fund for each fiscal year,

1 beginning with fiscal year 2026, the amounts that
2 would otherwise have been appropriated to carry out
3 the following programs:

4 “(A) The Medicare program under title
5 XVIII.

6 “(B) The Medicaid program under title
7 XIX, beginning as of 2033.

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

12 “(4) MEDICAID MAINTENANCE OF EFFORT PAY-
13 MENTS.—There shall be transferred to the Trust
14 Fund the maintenance of effort payments made
15 under section 2209.

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

21 “(d) INCORPORATION OF PROVISIONS.—The provi-
22 sions of subsections (b) through (i) of section 1817 shall
23 apply to the Trust Fund under this section in the same
24 manner as such provisions applied to the Federal Hospital
25 Insurance Trust Fund under such section 1817, except

1 that, for purposes of applying such subsections to this sec-
2 tion, the ‘Board of Trustees of the Trust Fund’ shall mean
3 the ‘Secretary’.

4 “(e) TRANSFER OF FUNDS.—Any amounts remain-
5 ing in the Federal Hospital Insurance Trust Fund under
6 section 1817 or the Federal Supplementary Medical Insur-
7 ance Trust Fund under section 1841 after the payment
8 of claims for items and services furnished under title
9 XVIII have been completed, shall be transferred into the
10 Trust Fund under this section.

11 **“SEC. 2208. ADMINISTRATIVE PROVISIONS.**

12 “(a) CENTER FOR HEALTH CARE.—Beginning 2028,
13 the Centers for Medicare & Medicaid Services shall be re-
14 named the Center for Health Care and all references in
15 law and regulation to such Centers shall be deemed a ref-
16 erence to such Center. All powers, duties, and responsibil-
17 ities of the Centers for Medicare & Medicaid Services shall
18 be transferred to the Center for Health Care.

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

22 “(c) ADMINISTRATIVE LAW JUDGES.—

23 “(1) IN GENERAL.—The Center for Health
24 Care is not authorized to appoint administrative law
25 judges, in accordance with pages 11420 through

1 11499 of title 70 of the Federal Register (March 8,
2 2005).

3 “(2) TIMING.—Under this title, administrative
4 law judges must issue a decision within 90 days of
5 receipt of a hearing request, as specified in sub-
6 sections (a) and (c) of section 405.1016 of title 2,
7 Code of Federal Regulations.

8 “(d) COVERAGE DETERMINATIONS APPEALS.—

9 “(1) Individuals may appeal a coverage deter-
10 mination under this title before the individual ob-
11 tains the service or item that is the subject of the
12 appeal. Individuals shall continue to receive the serv-
13 ice or item if an appeal is filed before the provision
14 of the service or item is terminated.

15 “(2) The Secretary shall eliminate the redeter-
16 mination by a Medicare administrative contractor
17 from the appeals process under the Medicare pro-
18 gram for beneficiaries.

19 “(e) PRIVATE RIGHT OF ACTION.—

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

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

3 “(A) prescribes, establishes, or confers a
4 benefit or protection in favor of the individual
5 or individuals seeking to enforce the provision;
6 or

7 “(B) prescribes, establishes, or imposes a
8 duty or obligation on a person or entity to act
9 or conduct operations in a manner that benefits
10 the individual or individuals seeking to enforce
11 the provision.

12 “(3) REASONABLE ATTORNEY FEES.—In any
13 action or proceeding to enforce this title, the court
14 may award reasonable attorneys’ fees and litigation
15 costs (including expert fees) reasonably incurred
16 against the defendant or defendants.

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

21 “(5) CONTINUED APPLICATION OF OTHER
22 LAWS.—Nothing in this title (or an amendment
23 made by this title) shall be construed to invalidate
24 or limit the rights, remedies, procedures, or legal
25 standards available to individuals aggrieved under

1 section 1979 of the Revised Statutes (42 U.S.C.
2 1983), or to supersede State laws causes of action.

3 “(f) NON-DISCRIMINATION.—

4 “(1) IN GENERAL.—Except as otherwise pro-
5 vided for in this title, an individual shall not, on the
6 ground prohibited under title VI of the Civil Rights
7 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of
8 the Education Amendments of 1972 (20 U.S.C.
9 1681 et seq.), the Age Discrimination Act of 1975
10 (42 U.S.C. 6101 et seq.), section 504 of the Reha-
11 bilitation Act of 1973 (29 U.S.C. 794), or section
12 1557 of the Affordable Care Act (42 U.S.C. 18116),
13 be excluded from participation in, be denied the ben-
14 efits of, or be subjected to discrimination under, any
15 health program or activity, any part of which is re-
16 ceiving Federal financial assistance, including cred-
17 its, subsidies, or contracts of insurance, or under
18 any program or activity that is administered by an
19 Executive Agency or any entity established under
20 this title (or amendments) or any employer-spon-
21 sored insurance. The enforcement mechanisms pro-
22 vided for and available under such title VI, title IX,
23 section 794, Age Discrimination Act, or such section
24 1557 shall apply for purposes of violations of this
25 subsection.

1 “(2) CONTINUED APPLICATION OF LAWS.—
2 Nothing in this title (or an amendment made by this
3 title) shall be construed to invalidate or limit the
4 rights, remedies, procedures, or legal standards
5 available to individuals aggrieved under title VI of
6 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
7 seq.), title VII of the Civil Rights Act of 1964 (42
8 U.S.C. 2000e et seq.), title IX of the Education
9 Amendments of 1972 (20 U.S.C. 1681 et seq.), sec-
10 tion 504 of the Rehabilitation Act of 1973 (29
11 U.S.C. 794), the Age Discrimination Act of 1975
12 (42 U.S.C. 611 et seq.), or section 1557 of the Af-
13 fordable Care Act (42 U.S.C. 18116) or to super-
14 sede State laws that provide additional protections
15 against discrimination on any basis described in
16 paragraph (1).

17 “(3) HEALTH CARE PROVIDERS.—Health care
18 providers may not be prohibited from participating
19 in the Medicare for America for reasons other than
20 their ability to provide covered services. Health care
21 providers and institutions are prohibited from deny-
22 ing covered individuals access to covered benefits
23 and services because of their religious objections.
24 This subsection supersedes any provision of law that
25 allows for conscience protection.

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

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

4 “(a) IN GENERAL.—A State is not eligible for pay-
5 ment under any program specified in subsection (c) for
6 a calendar quarter in a plan year beginning after 2036
7 unless the State makes to the Secretary for transfer to
8 the unified Medicare Trust Fund under section 2207 the
9 maintenance of effort payment applicable to such State
10 and plan year under subsection (b). The Secretary shall
11 extend such a waiver (including the availability of Federal
12 financial participation under such waiver) for such period
13 as may be required for a State to meet the requirement
14 of the previous sentence.

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

18 “(1) for plan year 2038 and a State, a payment
19 in an amount equal to the total amount of expendi-
20 tures of the State for medical assistance under title
21 XIX and child health assistance under title XXI in-
22 cluding administrative costs for the plan year before
23 the date of the enactment of this title;

24 “(2) for plan year 2039 and each subsequent
25 plan year before plan year 2043—

1 “(A) in the case of a State that is a
2 PPACA expansion State, the payment amount
3 applied under this subsection for the previous
4 plan year, increased by growth in GDP per cap-
5 ita plus 0.4 percent; and

6 “(B) in the case of a State that is not a
7 PPACA expansion State, the payment amount
8 applied under this subsection for the previous
9 plan year, increased by growth in GDP per cap-
10 ita plus 0.7 percent; and

11 “(3) beginning in 2043, for each subsequent
12 plan year, with respect to any State, the payment
13 amount applied under this subsection for the pre-
14 vious year, increased by growth in GDP per capita
15 plus 0.7 percent.

16 “(c) PROGRAMS SPECIFIED.—For purposes of this
17 section, the programs specified in this subsection are each
18 of the following:

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

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

24 “(3) Maternal and child health services block
25 grants under title V.

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

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

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

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

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

11 “Except as specified otherwise in this title, in imple-
12 menting Medicare for America, the Secretary shall to the
13 greatest extent practicable apply the following provisions
14 of title XVIII to the program under this title, benefits cov-
15 ered under this title, individuals entitled to benefits under
16 this title, and providers of services and suppliers partici-
17 pating under the program under this title in a similar
18 manner as such provisions applied to the program under
19 title XVIII, benefits covered under such title, individuals
20 entitled to benefits or enrolled under such title, and pro-
21 viders of services and suppliers participating under the
22 program under such title:

23 “(1) Section 1801.

24 “(2) Section 1805.

25 “(3) Section 1806.

- 1 “(4) Section 1807.
- 2 “(5) Section 1809.
- 3 “(6) Section 1814.
- 4 “(7) Section 1815.
- 5 “(8) Section 1816.
- 6 “(9) Section 1818.
- 7 “(10) Section 1818A.
- 8 “(11) Section 1819.
- 9 “(12) Section 1820.
- 10 “(13) Section 1834.
- 11 “(14) Section 1834A.
- 12 “(15) Section 1843.
- 13 “(16) Section 1846.
- 14 “(17) Section 1847.
- 15 “(18) Section 1851.
- 16 “(19) Section 1852.
- 17 “(20) Section 1855.
- 18 “(21) Section 1856.
- 19 “(22) Section 1857.
- 20 “(23) Section 1858.
- 21 “(24) Section 1861.
- 22 “(25) Section 1863.
- 23 “(26) Section 1864.
- 24 “(27) Section 1866B.
- 25 “(28) Section 1866C.

1 “(29) Section 1866E.

2 “(30) Section 1867.

3 “(31) Section 1868.

4 “(32) Section 1869.

5 “(33) Section 1871.

6 “(34) Section 1874A.

7 “(35) Section 1880.

8 “(36) Section 1881.

9 “(37) Section 1881A.

10 “(38) Section 1891.

11 “(39) Section 1894.

12 “(40) Section 1895.

13 “(41) Section 1896.

14 **“PART B—HOME- AND COMMUNITY-BASED LONG-**
15 **TERM SERVICES AND SUPPORTS**

16 **“SEC. 2231. HOME- AND COMMUNITY-BASED LONG-TERM**
17 **SERVICES AND SUPPORTS BENEFIT.**

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

1 **“SEC. 2232. ELIGIBILITY.**

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

6 “(1) The individual is eligible for Medicare for
7 America.

8 “(2) The individual is determined by a licensed
9 health care practitioner to be unable to perform,
10 without substantial assistance, at least one Activity
11 of Daily Living as described in section
12 7702B(c)(2)(B) of the Internal Revenue Code of
13 1986, or to require substantial assistance with one
14 or more of the following areas:

15 “(A) Communication.

16 “(B) Social interaction.

17 “(C) Learning.

18 “(D) Self-care.

19 “(E) Self-management.

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

22 “(b) CLARIFICATION.—Under this part, in the case
23 of an individual described in subsection (a) who experi-
24 ences periods in which their functional capacity changes
25 or improves, such individual shall continue to have access
26 to benefits under this part as needed. If such an individ-

1 ual’s functional capacity improves to a point in which the
2 individual no longer requires home- and community-based
3 long-term services and supports, or requires fewer serv-
4 ices, the individual shall be able to immediately and
5 seamlessly resume receiving all needed services if and
6 when their functional needs recur. Eligibility for services
7 shall be maintained if, without the services, the individual
8 would have reduced functional capacity. When assessing
9 functional impairment, the individual will be assessed
10 without regard to any current services or the ameliorative
11 effects of other mitigating measures described in section
12 3(4)(E)(i)(I) of the Americans With Disabilities Act of
13 1990.

14 “(c) BENEFITS.—

15 “(1) DEFINITION.—For purposes of this title,
16 the term ‘home- and community-based long-term
17 services and supports benefit’ means the daily living
18 supports needed by eligible individuals in order to
19 live, work, and participate in their communities, and
20 includes all home- and community-based services
21 and supports coverable as of the date of the enact-
22 ment of this title, under any State plan or waiver
23 under title XIX, including—

24 “(A) home health aides and homemakers;

1 “(B) direct support professionals and per-
2 sonal attendant care services;

3 “(C) hospice;

4 “(D) nursing care;

5 “(E) medical social services;

6 “(F) care coordination, including case
7 management, fiscal intermediary, and support
8 brokerage services;

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

11 “(H) behavioral health home- and commu-
12 nity-based long-term services and supports, in-
13 cluding assertive community treatment; peer
14 support services; intensive care coordination, in-
15 cluding case management; supported employ-
16 ment; and supported housing wraparound;

17 “(I) private-duty nursing;

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

20 “(K) transitional services to support an in-
21 dividual’s transition from an institutional set-
22 ting to the community.

23 “(2) NON-APPLICATION.—The provisions of sec-
24 tions 424.22(a)(1)(i) and 424.22(a)(1)(ii) of title 42
25 of the Code of Federal Regulations does not apply

1 in the case of the benefit described in paragraph
2 (1)(A).

3 “(d) HOME- AND COMMUNITY-BASED LONG-TERM
4 SERVICES AND SUPPORTS WORKFORCE DEVELOP-
5 MENT.—

6 “(1) IN GENERAL.—The Secretary shall ensure
7 that the number of individuals in the home- and
8 community-based long-term services and supports
9 workforce is adequate to ensure community integra-
10 tion for all beneficiaries under Medicare for Amer-
11 ica. In so doing, the Secretary may consider a wide
12 range of factors, including payment rates for direct
13 care workers, career pipelines and credentialing,
14 worker rights, and the impact of national labor poli-
15 cies.

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

23 “(3) COMMUNITY FIRST.—The benefit under
24 this part shall be arranged for and provided with a
25 community first presumption and eligible individuals

1 shall be provided home- and community-based long-
2 term services and support available under this sec-
3 tion, regardless of type or level of disability or serv-
4 ice need. No eligible individual may be referred to an
5 institution without first being offered and, if chosen,
6 provided home- and community-based long-term
7 services and supports. Individuals in an institution
8 on the effective date of the bill, and at least annually
9 or upon any change in condition thereafter, shall be
10 informed of, and if chosen, provided with home- and
11 community-based long-term services and supports.

12 “(e) ADMINISTRATION OF SERVICES AND SUP-
13 PORTS.—State entities responsible for administering
14 home- and community-based long-term services and sup-
15 port benefits under any State plan or waiver under title
16 XIX as of the date of the enactment of this title shall
17 continue to administer the benefits and services coverable
18 under this section.

19 “(f) COORDINATION WITH OTHER FEDERAL BENE-
20 FITS.—

21 “(1) RULE OF CONSTRUCTION.—Nothing in
22 this part shall be construed as prohibiting benefits
23 paid under this part from being used to compensate
24 a caregiver who provides community living assistance
25 services and supports to a dependent relative for

1 providing community living assistance services and
2 supports to an eligible individual under this part.

3 “(2) DEPENDENT RELATIVE DEFINED.—The
4 term ‘dependent relative’ means a child, grandchild,
5 niece, nephew, parent, grandparent, sibling, aunt, or
6 uncle (of such caregiver or his or her spouse or do-
7 mestic partner); such caregiver’s spouse or domestic
8 partner, if such child, grandchild, niece, nephew,
9 parent, grandparent, sibling, aunt, uncle, spouse, or
10 domestic partner is an eligible individual.

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

16 “(4) DISREGARD.—The benefit paid under this
17 part shall be disregarded for purposes of deter-
18 mining or continuing the eligibility of the individual
19 or the spouse of the individual for receipt of benefits
20 under any other Federal, State, or locally funded as-
21 sistance program, including benefits paid under title
22 II or XVI, under the laws administered by the Sec-
23 retary of Veterans Affairs, under low-income hous-
24 ing assistance programs, under the supplemental nu-
25 trition assistance program established under the

1 Food and Nutrition Act of 2008, or under programs
2 administered by State vocational rehabilitation agen-
3 cies.

4 “(5) REGULATIONS.—Not later than one year
5 after the date of the enactment of this section, the
6 Secretary shall promulgate such regulations as are
7 necessary to carry out this part and to prevent fraud
8 and abuse with respect to the benefits under this
9 part.

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

11 **“SEC. 2221. ALL PRIVATE PLANS.**

12 “(a) IN GENERAL.—For plan years beginning with
13 plan year 2029, a health insurance issuer may offer health
14 insurance coverage in the individual market only if such
15 issuer has entered into a contract with the Secretary
16 under subsection (b) to offer such coverage.

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

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

24 “(1) MA FOR AMERICA PLAN.—An MA for
25 America plan is a Medicare Advantage plan under

1 part C of title XVIII, except such plan shall provide
2 coverage for individuals enrolled under Medicare for
3 America under part A of this title, with respect to
4 at least the benefits covered under such part A.

5 “(2) MA FOR AMERICA SPONSOR.—An MA for
6 America sponsor is a sponsor of an MA for America
7 plan.

8 **“SEC. 2222. APPLICATION OF MEDICARE ADVANTAGE PRO-**
9 **VISIONS.**

10 “For purposes of applying this part, except as other-
11 wise specified under this part, the provisions of part C
12 of title XVIII, as in effect as of the date of the enactment
13 of this title shall apply with respect to an MA for America
14 sponsor, MA for America plan, individuals eligible for cov-
15 erage under this part, individuals enrolled under such
16 plan, and benefits covered under part A in a similar man-
17 ner and to a similar extent as such provisions applied to
18 an MA organization, MA plan, individuals eligible for
19 under part C of such title, individuals enrolled under an
20 MA plan, and benefits covered under fee-for-service Medi-
21 care as of such date.

22 **“SEC. 2223. MEDICARE ADVANTAGE FOR AMERICA PAY-**
23 **MENT RATES.**

24 “The rates for Medicare Advantage for America
25 plans shall be equal to the rates paid by Medicare for

1 America. The Administrator of the Center for Healthcare
2 shall pay Medicare Advantage for America plans 90 per-
3 cent of average Medicare for America costs in each county.

4 **“SEC. 2224. SEPARATE PREMIUM FOR MEDICARE ADVAN-**
5 **TAGE FOR AMERICA PLANS FURNISHING**
6 **SUPPLEMENTAL BENEFITS.**

7 “Nothing in this part shall preclude an individual
8 from choosing a Medicare Advantage for America plan
9 which requires the individual to pay an additional, sepa-
10 rate amount because of supplemental benefits or because
11 it is a more expensive plan. In such case the individual
12 enrolled under such plan would be responsible for a sepa-
13 rate monthly premium.

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

16 “Medicare Advantage for America plans, for prescrip-
17 tion drugs, shall pay no more than the price negotiated
18 under Medicare for America.

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

20 “Medicare Advantage for America plans may not pay
21 fees to insurance brokers.

1 **“SEC. 2227. CLARIFICATION ON MEDICARE ADVANTAGE EM-**
2 **PLOYER GROUP WAIVER PLANS AND THE**
3 **MEDICARE SECONDARY PAYER REQUIRE-**
4 **MENT.**

5 “Such plans shall be exempt from the MSP Require-
6 ment, and nothing in this section shall be construed as
7 prohibiting such plans from contributing to the payment
8 of premiums and cost-sharing.

9 **“SEC. 2228. REFERENCES.**

10 “Beginning in 2029, all references in law and regula-
11 tion to Medicare Advantage shall be deemed a reference
12 to Medicare Advantage for America.””.

13 **SEC. 112. MODIFICATIONS TO AND COORDINATION WITH**
14 **EXISTING FEDERAL HEALTH PROGRAMS.**

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

17 (1) IN GENERAL.—Notwithstanding any other
18 provision of law, subject to paragraphs (2) and (3)
19 and section 2202(c) of the Social Security Act, as
20 added by section 111—

21 (A) no benefits shall be available under
22 title XVIII of the Social Security Act for any
23 item or service furnished—

24 (i) beginning on or after January 1,
25 2030 (except in the case of an individual

1 enrolled under such title and title XIX of
2 such Act); and

3 (ii) beginning on or after January 1,
4 2033, with respect to all individuals, in-
5 cluding individuals enrolled under such
6 title and title XIX of such Act;

7 (B) no individual is entitled to medical as-
8 sistance under a State plan approved under
9 title XIX of such Act—

10 (i) for any item or service furnished
11 on or after January 1, 2033, in the case
12 of an individual enrolled under such title
13 and title XVIII of the Social Security Act
14 or an individual described in subclause
15 (VIII) of section 1902(a)(10)(A)(i); and

16 (ii) for any item or service furnished
17 on or after January 1, 2035;

18 (C) no individual is entitled to medical as-
19 sistance under a State child health plan under
20 title XXI of such Act for any item or service
21 furnished on or after January 1, 2033; and

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

1 (i) for any item or service furnished
2 on or after January 1, 2033, in the case
3 of an individual enrolled under such title
4 and title XVIII of the Social Security Act
5 or an individual described in subclause
6 (VIII) of section 1902(a)(10)(A)(i); and

7 (ii) for any item or service furnished
8 on or after January 1, 2035.

9 (2) TRANSITION.—In the case of inpatient hos-
10 pital services and extended care services during a
11 continuous period of stay which began before Janu-
12 ary 1, 2033, for Medicare and 2035 for Medicaid or
13 CHIP, and which had not ended as of such date, for
14 which benefits are provided under title XVIII of the
15 Social Security Act, under a State plan under title
16 XIX of such Act, or under a State child health plan
17 under title XXI such Act, the Secretary of Health
18 and Human Services shall provide for continuation
19 of benefits under such title or plan until the end of
20 the period of stay.

21 (b) OTHER FEDERAL HEALTH PROGRAMS.—

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

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

5 (3) TREATMENT OF BENEFITS FOR VETERANS
6 AND NATIVE AMERICANS.—

7 (A) IN GENERAL.—Nothing in this Act, or
8 the amendments made by this Act, shall affect
9 the eligibility of veterans for the medical bene-
10 fits and services provided under title 38, United
11 States Code, or of Indians for the medical bene-
12 fits and services provided by or through the In-
13 dian Health Service.

14 (B) REEVALUATION.—No reevaluation of
15 the Indian Health Service shall be undertaken
16 without consultation with tribal leaders and
17 stakeholders.

18 (C) SUPPLEMENTAL INDIAN HEALTH
19 SERVICES ALLOCATION.—The Secretary shall
20 annually determine the need to provide an allot-
21 ment of supplemental funds to Indian Health
22 Services, including payments to providers,
23 health professional education, administrative ex-
24 penses, and prevention and public health activi-
25 ties.

1 (4) ENROLLEE CHOICE.—Nothing in this Act
2 shall preclude individuals enrolled in the Federal
3 Employees Health Benefits Program or TRICARE
4 or individuals receiving benefits provided under title,
5 38, United States Code or the Indian Health Service
6 from enrolling in Medicare for America. Enrollees
7 shall be entitled to the employer contribution as es-
8 tablished under section 126(c) of such Act.

9 (c) SUNSET OF PROVISIONS RELATED TO THE STATE
10 EXCHANGES.—Effective January 1, 2033, the Federal
11 and State Exchanges established pursuant to title I of the
12 Patient Protection and Affordable Care Act (Public Law
13 111–148) shall terminate, and any other provision of law
14 that relies upon participation in or enrollment through
15 such an Exchange, including such provisions of the Inter-
16 nal Revenue Code of 1986, shall cease to have force or
17 effect.

18 (d) SEVERABILITY.—Every provision in this Act and
19 every application of the provisions in this Act are severable
20 from each other as a matter of Federal law. If any applica-
21 tion of any provision in this Act to any person or group
22 of persons or circumstances is found by a court to be in-
23 valid, the remainder of this Act and the application of the
24 Act’s provisions to all other persons and circumstances
25 may not be affected.

1 **Subtitle C—Targeted Reforms**

2 **SEC. 121. LIMITATION ON REMOVAL OF MEDICARE ADVAN-**
3 **TAGE PROVIDERS BY MA ORGANIZATIONS.**

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

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

9 “(A) REMOVAL OF PROVIDERS WITH
10 CAUSE.—Beginning with plan year 2028, except
11 as provided in subparagraph (C), an MA orga-
12 nization offering an MA plan may only remove
13 a provider of services or a supplier from a net-
14 work of such plan if the organization has cause
15 to remove such provider or supplier.

16 “(B) CAUSE TO REMOVE PROVIDERS.—

17 “(i) IN GENERAL.—An MA organiza-
18 tion offering an MA plan has cause to re-
19 move a provider of services or a supplier
20 from a network of such plan if the Sec-
21 retary determines that the provider or sup-
22 plier is—

23 “(I) medically negligent;

24 “(II) in violation of any legal or
25 contractual requirement applicable to

1 the provider or supplier acting within
2 the lawful scope of practice, including
3 any participation or other requirement
4 applicable to such provider or supplier
5 under this title or under any contrac-
6 tual term for such plan; or

7 “(III) otherwise unfit to furnish
8 items and services in accordance with
9 requirements of this title.

10 “(ii) CONSIDERATION OF COST TO MA
11 ORGANIZATIONS.—For purposes of sub-
12 paragraph (A), cost to an MA organization
13 offering an MA plan due to the participa-
14 tion of a provider of services or supplier in
15 a network of such plan does not constitute
16 cause for the MA organization to remove
17 such provider or supplier from the network
18 mid-year, and such cost may not be consid-
19 ered as a factor in favor of a determination
20 that such organization has cause to remove
21 the provider.

22 “(C) EXCEPTION.—With respect to each
23 upcoming plan year, beginning with plan year
24 2028, an MA organization offering an MA plan
25 may only remove a provider of services or sup-

1 plier from a network of such plan for reasons
2 not specified in subparagraph (B)(i) before the
3 date that is 60 days before the first day of the
4 annual coordinated election period for such plan
5 year under section 1851(e)(3).

6 “(D) NOTICE AND APPEAL PROCESS.—

7 “(i) IN GENERAL.—Any removal of a
8 provider of services or supplier from a net-
9 work of an MA plan may occur only after
10 the completion of a fair notice and appeal
11 process that the Secretary shall establish
12 by regulation. Such process shall require
13 the MA organization to provide to such
14 provider or supplier and to the Secretary
15 an explanation of the reason or reasons for
16 the removal. The Secretary shall make this
17 information publicly available.

18 “(ii) APPLICATION.—

19 “(I) APPLICATION OF NEW PROC-
20 ESS.—In the case of a removal of a
21 provider of services or supplier from a
22 network of an MA plan occurring on
23 or after the effective date published in
24 a final rule for such fair notice and
25 appeal process, such process shall

1 apply in lieu of the process for the
2 termination or suspension of a pro-
3 vider contract under section
4 422.202(a) of title 42, Code of Fed-
5 eral Regulations.

6 “(II) CONTINUATION OF OLD
7 PROCESS.—In the case of a removal of
8 a provider of services or supplier from
9 a network of an MA plan occurring
10 before such effective date, the process
11 for the termination or suspension of a
12 provider contract under section
13 422.202(a) of title 42, Code of Fed-
14 eral Regulations, shall apply.

15 “(E) PARTICIPANT NOTICE AND PROTEC-
16 TION.—

17 “(i) NOTICE TO PARTICIPANTS OF
18 PROVIDER REMOVAL.—Not less than 60
19 days before the date on which a provider
20 of services or supplier is removed from a
21 network of an MA plan, the MA organiza-
22 tion offering such plan shall provide writ-
23 ten notification of the removal to each in-
24 dividual enrolled in such plan receiving
25 items or services from the provider or sup-

plier during the plan year in effect on the date of removal or during the previous plan year. Such notification shall include at the minimum—

“(I) the names and telephone numbers of available in-network providers of services and suppliers offering items and services that are the same or similar to the items and services offered by the removed provider or supplier;

“(II) information regarding the options available to an individual enrolled in such plan to request the continuation of medical treatment or therapy with the removed provider or supplier; and

“(III) one or more customer service telephone numbers that an individual enrolled in such plan may access to obtain information regarding changes to the network of the plan.

“(ii) ANNUAL NOTICE OF CHANGE.—
In addition to providing the notification of removal as required under clause (i), the

1 MA organization offering such MA plan
2 shall include such notification in the an-
3 nual notice of change for the MA plan for
4 the upcoming plan year.

5 “(iii) CONTINUITY OF CARE.—In any
6 case in which a provider of services or sup-
7 plier is removed from a network of an MA
8 plan, such plan shall ensure that the re-
9 moval satisfies the continuity of care re-
10 quirements under paragraph (1)(A) with
11 respect to each individual enrolled in such
12 plan receiving items or services from the
13 provider or supplier during the plan year
14 in effect on the date of removal or during
15 the previous plan year.

16 “(F) RULE OF CONSTRUCTION.—Nothing
17 in this paragraph shall be construed as affect-
18 ing the ability of a provider of services or sup-
19 plier to decline to participate in a network of an
20 MA plan.

21 “(8) TRANSPARENCY IN MEASURES USED BY
22 MA ORGANIZATIONS TO ESTABLISH OR MODIFY PRO-
23 VIDER NETWORKS.—

24 “(A) IN GENERAL.—Beginning with plan
25 year 2028, an MA organization offering an MA

1 plan shall publish and make accessible the in-
2 formation described in subparagraph (B)—

3 “(i) in the annual bid information
4 submitted by the MA organization with re-
5 spect to the MA plan under section 1854;
6 and

7 “(ii) on the Internet Web Site for the
8 MA plan.

9 “(B) INFORMATION DESCRIBED.—The in-
10 formation described in this subparagraph is the
11 following:

12 “(i) Information regarding the meas-
13 ures used by the MA organization to estab-
14 lish or modify the provider network of the
15 MA plan, including measures of the quality
16 and efficiency of providers. Such informa-
17 tion shall include the specifications, meth-
18 odology, and sample size of such measures.

19 “(ii) Other information related to the
20 establishment or modification of such pro-
21 vider network that the Secretary deter-
22 mines appropriate.

23 “(C) LIMITATION.—The information de-
24 scribed in subparagraph (B) shall not include

1 any individually identifiable information of any
2 provider or supplier of services.”.

3 (b) ENFORCEMENT.—

4 (1) SANCTIONS FOR NONCOMPLIANCE.—Section
5 1857(g)(1) of the Social Security Act (42 U.S.C.
6 1395w–27(g)(1)) is amended—

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

8 (B) by redesignating subparagraph (K) as
9 subparagraph (L);

10 (C) by inserting after subparagraph (J)
11 the following new subparagraph:

12 “(K) fails to comply with section
13 1852(d)(7) or 1852(d)(8); or”; and

14 (D) in subparagraph (L) (as so redesign-
15 ated), by striking “through (J)” and inserting
16 “through (K)”.

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

18 Title XVIII of the Social Security Act is amended—

19 (A) in section 1860D–12(b)(3)(E) (42
20 U.S.C. 1395w—

21 (B) in section 1894(e)(6)(B) (42 U.S.C.
22 1395eee(e)(6)(B)), by inserting “(other than
23 paragraph (1)(K) of such section)” after
24 “1857(g)(1)”.

1 (c) MEDICARE ADVANTAGE PLAN COMPARE TOOL.—
2 Not later than one year after the date of enactment of
3 this Act, the Secretary of Health and Human Services
4 shall take such measures as are necessary to ensure that
5 the Medicare Advantage Compare Tool takes into account
6 the preferences and utilization needs of such individuals.

7 **SEC. 122. NETWORK ADEQUACY.**

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

11 “(9) NETWORK ADEQUACY REQUIREMENTS.—
12 Beginning in plan year 2028, notwithstanding any
13 other provision of law, the following shall apply:

14 “(A) PROVIDER AVAILABILITY.—When es-
15 tablishing a plan network, a Medicare Advan-
16 tage organization offering an MA plan shall,
17 among other factors determined by the Sec-
18 retary, consider the following:

19 “(i) The anticipated enrollment in the
20 plan.

21 “(ii) The expected types of services
22 provided and utilization of services by en-
23 rollees under the plan.

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

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

3 “(v) The location of providers and en-
4 rollees, taking into account geographic dis-
5 bursement.

6 “(vi) The full-time equivalent avail-
7 ability of a provider to provide such serv-
8 ices.

9 “(B) PROVISION OF CARE IN A TIMELY
10 MANNER.—A Medicare Advantage organization
11 offering an MA plan shall ensure that providers
12 are able to provide services in a timely manner,
13 as defined by the Secretary, under the plan.

14 “(C) APPLICATION OF NETWORK ACCESS
15 ADEQUACY STANDARDS.—In applying the net-
16 work access adequacy standards pursuant to
17 paragraph (1), the Secretary shall seek input
18 from patient advocacy groups, providers of serv-
19 ices and suppliers, and MA plans under this
20 part.

21 “(D) CERTIFICATION.—Each plan year, a
22 Medicare Advantage organization shall certify
23 to the Secretary, with respect to each MA plan
24 offered by the organization, that the providers,
25 including specialists and subspecialists, in the

1 plan network are able to provide the services re-
2 quired under the organization’s contract with
3 the Secretary under section 1857 with respect
4 to the offering of such plan and to meet the
5 needs of the enrollees within the plan service
6 area during the year.

7 “(E) ANNUAL REPORTING.—Each plan
8 year, a Medicare Advantage organization shall
9 report to the Secretary, and make public the
10 following with respect to each MA plan offered
11 by the organization:

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

15 “(ii) UTILIZATION OF OUT-OF-NET-
16 WORK PROVIDERS.—The utilization of out-
17 of-network providers under the plan.

18 “(iii) AVERAGE COST PER PATIENT.—
19 The average annual spending per patient
20 for primary and specialty care for enrollees
21 under the plan.

22 “(F) CERTIFICATION.—In advance of the
23 annual, coordinated election period under sec-
24 tion 1851(e)(3), a Medicare Advantage organi-
25 zation shall certify to the Secretary the accu-

1 racy of provider directories for each plan of-
2 fered by the organization.

3 “(G) NETWORK REVIEW.—The Secretary
4 shall ensure that the network of each MA plan
5 offered by a Medicare Advantage organization
6 meets the network adequacy guidelines estab-
7 lished under this paragraph and under section
8 422.112(a)(4) of title 42, Code of Federal Reg-
9 ulations (or any successor regulation to such
10 section) at least once every 3 years or when a
11 material change in network occurs.

12 “(H) AUTHORITY.—The Secretary shall
13 have the authority to stop any further enroll-
14 ment in a Medicare Advantage plan if there is
15 a pattern of excessive violations of this para-
16 graph.”.

17 (b) ENFORCEMENT.—Section 1857(g)(1)(K) of the
18 Social Security Act (42 U.S.C. 1395w–27(g)(1)(K)), as
19 added by section 2(b), is amended by striking “or
20 1852(d)(8)” and inserting “, 1852(d)(8), or 1852(d)(9)”.

21 **SEC. 123. ELIMINATING THE 24-MONTH WAITING PERIOD**
22 **FOR MEDICARE COVERAGE FOR INDIVID-**
23 **UALS WITH DISABILITIES.**

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

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

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

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

8 (4) in the first sentence, by striking “for each
9 month beginning with the later of (I) July 1973 or
10 (II) the twenty-fifth month of his entitlement or sta-
11 tus as a qualified railroad retirement beneficiary de-
12 scribed in paragraph (2), and” and inserting “for
13 each month for which the individual meets the re-
14 quirements of paragraph (2), beginning with the
15 month following the month in which the individual
16 meets the requirements of such paragraph, and”;
17 and

18 (5) in the second sentence, by striking “the”
19 twenty-fifth month of his entitlement“” and all that
20 follows through “paragraph (2)(C) and”.

21 (b) CONFORMING AMENDMENTS.—

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

24 (A) striking subsections (e)(1)(B), (f), and
25 (h); and

1 (B) redesignating subsections (g) and (i)
2 as subsections (f) and (g), respectively.

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

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

11 (4) RAILROAD RETIREMENT SYSTEM.—Section
12 7(d)(2)(ii) of the Railroad Retirement Act of 1974
13 (45 U.S.C. 231f(d)(2)(ii)) is amended—

14 (A) by striking “has been entitled to an
15 annuity” and inserting “is entitled to an annu-
16 ity”;

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

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

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to insurance benefits under title
23 XVIII of the Social Security Act with respect to items and
24 services furnished in months beginning after the date of
25 enactment of this Act.

1 **SEC. 124. ELIMINATING THE WAITING PERIOD FOR INDIVIDUALS ON STATE MEDICAID WAITING**
2 **LISTS.**

3
4 The Secretary of Health and Human Services is ap-
5 propriated such sums as are necessary to facilitate enroll-
6 ment, not later than 90 days after the date of the enact-
7 ment of this Act, all eligible individuals who, as of the
8 date of the enactment of this Act, are on State Medicaid
9 waiting lists or State Medicaid waiver waiting lists.

10 **SEC. 125. EMPLOYER HEALTH PLAN OPTIONS.**

11 (a) DEFINITION.—A qualifying employer-sponsored
12 plan is—

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

16 (2) any other plan or coverage that meets the
17 criteria under subsection (b), includes vision, dental,
18 and hearing benefits, and provides health coverage
19 that is equivalent to an actuarial value of at least 80
20 percent of the coverage provided under title XXII of
21 the Social Security Act and makes a premium con-
22 tribution of at least 70 percent.

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

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

3 (1) offer a qualifying employer-sponsored plan
4 to such employee, in accordance with subsection (a);
5 or

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

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

23 (d) EMPLOYEE EDUCATION ON HEALTH COVERAGE
24 OPTIONS.—Large employers shall disseminate to employ-
25 ees such publicly available information on coverage options

1 under Medicare for America as the Secretary deems ap-
2 propriate, including contact information for assistance.

3 (e) SPECIAL RULES.—

4 (1) ANNUAL PAYROLL.—For purposes of this
5 paragraph, the term “annual payroll” means, with
6 respect to any employer for any calendar year, the
7 aggregate wages paid by the employer during such
8 calendar year.

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

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

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

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

1 (B) PART-TIME EMPLOYMENT RATIO.—

2 The term “part-time employment ratio” means,
3 with respect to a part-time employee of an em-
4 ployer in a month, a fraction—

5 (i) the numerator of which is the
6 number of hours in the employee’s normal
7 work week; and

8 (ii) the denominator of which is 30
9 hours.

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

19 (D) CONVERSION TO HOURS OF EMPLOY-
20 MENT.—The Secretary of Health and Human
21 Services, in consultation with the Secretary of
22 the Treasury, shall establish rules for the con-
23 version of compensation to hours of employ-
24 ment, for purposes of this subsection in the
25 case of employees that receive compensation on

1 a salaried basis, or on the basis of a commis-
2 sion, or other contingent or bonus basis, rather
3 than based on an hourly wage.

4 (f) TIMING AND MANNER.—Each employer that
5 makes a financial contribution under subsection (b)(2)
6 and (c) under this section (other than with respect to cov-
7 erage under a group health plan) shall pay such contribu-
8 tion in a form and manner, specified by the Secretary of
9 the Treasury, based upon the form and manner in which
10 employer excise taxes are required to be paid under section
11 3111 of the Internal Revenue Code of 1986.

12 (g) NON-DISCRIMINATION.—

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

1 or contracts of insurance, or under any program or
2 activity that is administered by an Executive Agency
3 or any entity established under this title (or amend-
4 ments) or any employer-sponsored insurance.

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

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

1 (4) REGULATIONS.—The Secretary of Health
2 and Human Services, in conjunction with the Sec-
3 retary of Labor, may promulgate regulations to im-
4 plement this subsection.

5 **SEC. 126. PROHIBITION ON STEP THERAPY AND PRIOR AU-**
6 **THORIZATION UNDER GROUP HEALTH**
7 **PLANS.**

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

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

18 **SEC. 127. MEDICARE OUTPATIENT OBSERVATION SERV-**
19 **ICES.**

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

1 discharge date (unless such individual is admitted as a
2 hospital inpatient at the end of such period)’’.

3 **SEC. 128. ABORTION COVERAGE.**

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

7 **SEC. 129. APPLICABILITY OF MENTAL HEALTH PARITY.**

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

13 **SEC. 130. STUDENT LOAN FORGIVENESS FOR HEALTH CARE**
14 **PROVIDERS PARTICIPATING IN MEDICARE**
15 **FOR AMERICA.**

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

1 mits an employment certification form described in sub-
2 section (d).

3 (b) APPLICABLE PERCENT.—For purposes of sub-
4 section (a), the applicable percent is 10 percent of any
5 eligible Federal loan for each year the health care provider
6 participates in Medicare for America.

7 (c) DEFINITIONS.—In this section:

8 (1) ELIGIBLE FEDERAL LOAN.—The term “eli-
9 gible Federal loan” means any loan made under part
10 D of title IV of the Higher Education Act of 1965
11 (20 U.S.C. 1087a).

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

24 (3) MEDICARE FOR AMERICA PARTICIPATING
25 PROVIDER.—The term “Medicare for America par-

1 ticipating provider” means a health care provider
2 that meets the definition of such term under section
3 105 or works at a participating provider or entity as
4 defined under section 105.

5 (d) EMPLOYMENT CERTIFICATION FORM.—

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

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

21 (e) INTEREST CANCELED.—If a portion of a loan is
22 canceled under this section for any year, the entire amount
23 of interest on such loan that accrues for such year shall
24 be canceled.

1 (f) REGULATIONS.—The Secretary of Health and
2 Human Services and the Secretary of Education may pro-
3 mulgate regulations to implement this section.

4 **SEC. 131. CLARIFICATION OF THE DEFINITION OF PEDI-**
5 **ATRIC MEDICAL NECESSITY IN QUALIFYING**
6 **GROUP COVERAGE.**

7 (a) DEFINITION.—The following definition of pedi-
8 atric medical necessity shall be incorporated into benefit
9 standards of all plans subject to the requirements of sec-
10 tion 1302 of the Patient Protection and Affordable Care
11 Act (42 U.S.C. 18022) and all group plans by 2026.

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

22 (c) UPDATES TO DEFINITION.—The Secretary of
23 Health and Human Services, in consultation with experts
24 in the field of pediatric care and key stakeholders, includ-
25 ing patient and family groups, shall review and update this

1 definition on a biennial basis, consistent with up-to-date
2 standards of pediatric healthcare practice that are based
3 on—

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

6 (2) recommendations of medical-specialty soci-
7 eties, other pediatric healthcare provider organiza-
8 tions, and family and patient groups; and

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

12 **SEC. 132. SAFE STAFFING REQUIREMENTS.**

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

17 **“TITLE XXXIV—MINIMUM DI-**
18 **RECT CARE REGISTERED**
19 **NURSE STAFFING REQUIRE-**
20 **MENT**

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

22 **“(a) STAFFING PLAN.—**

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

1 “(A) provides adequate, appropriate, and
2 quality delivery of health care services and pro-
3 tects patient safety; and

4 “(B) is consistent with the requirements of
5 this title.

6 “(2) EFFECTIVE DATES.—

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

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

18 “(i) 2028; and

19 “(ii) in the case of a hospital in a
20 rural area (as defined in section
21 1886(d)(2)(D) of the Social Security Act),
22 2030.

23 “(b) MINIMUM DIRECT CARE REGISTERED NURSE-
24 TO-PATIENT RATIOS.—

1 “(1) IN GENERAL.—Except as provided in para-
2 graph (4) and other provisions of this section, a hos-
3 pital’s staffing plan shall provide that, at all times
4 during each shift within a unit of the hospital, and
5 with a full complement of ancillary and support
6 staff, a direct care registered nurse may be assigned
7 to not more than the following number of patients
8 in that unit:

9 “(A) One patient in trauma emergency
10 units.

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

14 “(C) Two patients in critical care units, in-
15 cluding neonatal intensive care units, emer-
16 gency critical care and intensive care units,
17 labor and delivery units, coronary care units,
18 acute respiratory care units, postanesthesia
19 units, and burn units.

20 “(D) Three patients in emergency room
21 units, pediatrics units, stepdown units, telem-
22 etry units, antepartum units, and combined
23 labor, delivery, and postpartum units.

24 “(E) Four patients in medical-surgical
25 units, intermediate care nursery units, acute

1 care psychiatric units, and other specialty care
2 units.

3 “(F) Five patients in rehabilitation units
4 and skilled nursing units.

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

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

16 “(3) APPLICATION OF RATIOS TO HOSPITAL
17 NURSING PRACTICE STANDARDS.—

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

1 “(B) DEMONSTRATION OF UNIT-SPECIFIC
2 COMPETENCE.—A hospital shall not assign a di-
3 rect care registered nurse to a hospital unit un-
4 less that hospital determines that the direct
5 care registered nurse has demonstrated current
6 competence in providing care in that unit, and
7 has also received orientation to that hospital’s
8 unit sufficient to provide competent care to pa-
9 tients in that unit.

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

19 “(D) NURSE ADMINISTRATORS AND SU-
20 PERVISORS.—A registered nurse who is a nurse
21 administrator, nurse supervisor, nurse manager,
22 charge nurse, case manager, or any other hos-
23 pital administrator or supervisor, shall not be
24 included in the calculation of the direct care
25 registered nurse-to-patient ratio unless that

1 nurse has a current and active direct patient
2 care assignment and provides direct patient
3 care in compliance with the requirements of this
4 section, including competency requirements.
5 The exemption in this subsection shall apply
6 only during the hours in which the individual
7 registered nurse has the principal responsibility
8 of providing direct patient care and has no ad-
9 ditional job duties as would a direct care reg-
10 istered nurse.

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

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

1 “(G) ANCILLARY AND ADDITIONAL STAFF-
2 ING.—The need for additional staffing of direct
3 care registered nurses, licensed vocational or
4 practical nurses, licensed psychiatric techni-
5 cians, certified nursing or patient care assist-
6 ants, or other licensed or unlicensed ancillary
7 staff above the minimum registered nurse-to-pa-
8 tient ratios shall be based on the assessment of
9 the individual patient’s nursing care require-
10 ment, the individual patient’s nursing care plan,
11 and acuity level.

12 “(4) RESTRICTIONS.—

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

20 “(B) PROHIBITION AGAINST IMPOSITION
21 OF MANDATORY OVERTIME REQUIREMENTS.—A
22 hospital shall not impose mandatory overtime
23 requirements to meet the hospital unit direct
24 care registered nurse-to-patient ratios required
25 under this subsection.

1 “(C) RELIEF DURING ROUTINE AB-
2 SENCES.—A hospital shall ensure that only a
3 direct care registered nurse who has dem-
4 onstrated current competence to the hospital in
5 providing care on a particular unit and has also
6 received orientation to that hospital’s unit suffi-
7 cient to provide competent care to patients in
8 that unit may relieve another direct care reg-
9 istered nurse during breaks, meals, and other
10 routine, expected absences from a hospital unit.

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

1 tient care area, and shall comply with all other
2 requirements of this section.

3 “(E) USE OF VIDEO MONITORS.—A hos-
4 pital shall not employ video monitors or any
5 form of electronic visualization of a patient as
6 a substitute for the direct observation required
7 for patient assessment by the direct care reg-
8 istered nurse or required for patient protection.
9 Video monitors or any form of electronic visual-
10 ization of a patient shall not be included in the
11 calculation of the direct care registered nurse-
12 to-patient ratio required in this subsection and
13 shall not replace the requirement of paragraph
14 (3)(D) that each patient shall be assigned to a
15 direct care registered nurse who shall directly
16 provide the assessment, planning, supervision,
17 implementation, and evaluation of the nursing
18 care provided to the patient at least every shift
19 and have the responsibility for the provision of
20 care to a particular patient within his or her
21 scope of practice.

22 “(F) USE OF OTHER TECHNOLOGY.—A
23 hospital shall not employ technology that sub-
24 stitutes for the assigned registered nurse’s pro-

1 fessional judgment in assessment, planning, im-
2 plementation, and evaluation of care.

3 “(5) ADJUSTMENT OF RATIOS.—

4 “(A) IN GENERAL.—If necessary to protect
5 patient safety, the Secretary may prescribe reg-
6 ulations that—

7 “(i) increase minimum direct care reg-
8 istered nurse-to-patient ratios under this
9 subsection to reduce the number of pa-
10 tients that may be assigned to each direct
11 care nurse; or

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

15 “(B) CONSULTATION.—Such regulations
16 shall be prescribed after consultation with af-
17 fected hospitals and registered nurses.

18 “(6) ANCILLARY AND ADDITIONAL STAFFING.—

19 “(A) IN GENERAL.—The Secretary may
20 prescribe regulations requiring additional staff-
21 ing of direct care registered nurses, licensed vo-
22 cational or practice nurses, licensed psychiatric
23 technicians, certified nursing or patient care as-
24 sistants, or other licensed or unlicensed ancil-
25 lary staff above the minimum registered nurse-

1 to-patient ratios that is based on the assess-
2 ment of the individual patient's nursing care
3 needs, the individual patient's nursing care
4 plan, and acuity level.

5 “(B) CONSULTATION.—Such regulations
6 shall be prescribed after consultation with af-
7 fected hospitals, registered nurses, and ancillary
8 staff.

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

19 “(8) EXEMPTION IN EMERGENCIES.—The re-
20 quirements established under this subsection shall
21 not apply during a state of emergency if a hospital
22 is requested or expected to provide an exceptional
23 level of emergency or other medical services. If a
24 hospital seeks to apply the exemption under this
25 paragraph in response to a complaint filed against

1 the hospital for a violation of the provisions of this
2 title, the hospital must demonstrate that prompt and
3 diligent efforts were made to maintain required
4 staffing levels. The Secretary shall issue guidance to
5 hospitals that describes situations that constitute a
6 state of emergency for purposes of the exemption
7 under this paragraph and shall establish necessary
8 penalties for violations of this paragraph consistent
9 with section 3406.

10 “(c) DEVELOPMENT AND REEVALUATION OF STAFF-
11 ING PLAN.—

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

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

21 “(B) The acuity level and nursing care
22 plan of patients on a particular unit on a shift-
23 by-shift basis.

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

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

6 “(E) Staffing levels and services provided
7 by licensed vocational or practical nurses, li-
8 censed psychiatric technicians, certified nurse
9 assistants, or other ancillary staff in meeting
10 direct patient care needs not required by a di-
11 rect care registered nurse.

12 “(F) The level of familiarity with hospital
13 practices, policies, and procedures by temporary
14 agency direct care registered nurses used dur-
15 ing a shift.

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

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

21 “(3) ANNUAL REEVALUATION OF PLAN.—

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

1 “(B) UPDATE.—A hospital shall update its
2 staffing plan to the extent appropriate based on
3 such evaluation.

4 “(4) TRANSPARENCY.—

5 “(A) IN GENERAL.—Any staffing plan or
6 method used to create and evaluate acuity-level
7 and adopted by a hospital under this section
8 shall be transparent in all respects, including
9 disclosure of detailed documentation of the
10 methodology used to determine nursing staff-
11 ing, identifying each factor, assumption, and
12 value used in applying such methodology.

13 “(B) PUBLIC AVAILABILITY.—The Sec-
14 retary shall establish procedures to provide that
15 the documentation submitted under subsection
16 (d) is available for public inspection in its en-
17 tirety.

18 “(5) REGISTERED NURSE PARTICIPATION.—A
19 staffing plan of a hospital—

20 “(A) shall be developed and subsequent re-
21 evaluations shall be conducted under this sub-
22 section on the basis of input from direct care
23 registered nurses at the hospital from each unit
24 or patient care area; and

1 “(B) where such nurses are represented
2 through collective bargaining, shall require bar-
3 gaining with the applicable recognized or cer-
4 tified collective bargaining representative of
5 such nurses. Nothing in this title shall be con-
6 strued to permit conduct prohibited under the
7 National Labor Relations Act or chapter 71 of
8 title 5, United States Code.

9 “(6) STAFFING COMMITTEES.—If a hospital
10 maintains a staffing committee, then the committee
11 shall include at least one registered nurse from each
12 hospital unit and shall be composed of at least 50
13 percent direct care registered nurses. The staffing
14 committee shall include meaningful representation of
15 other direct care nonmanagement staff. Direct care
16 registered nurses who serve on the committee shall
17 be selected by other direct care registered nurses
18 from their unit. Other direct care nonmanagement
19 staff shall be selected by other direct care non-
20 management staff. Participation on staffing commit-
21 tees shall be considered a part of the employee’s reg-
22 ularly scheduled work week.

23 “(d) SUBMISSION OF PLAN TO SECRETARY.—A hos-
24 pital shall submit to the Secretary its staffing plan and
25 any annual updates under subsection (c)(3)(B). A feder-

1 ally operated hospital may submit its staffing plan
2 through the department or agency operating the hospital.

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

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

7 “(1) explains requirements imposed under sec-
8 tion 3401;

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

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

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

16 “(b) RECORDS.—

17 “(1) MAINTENANCE OF RECORDS.—Each hos-
18 pital shall maintain accurate records of actual direct
19 care registered nurse-to-patient ratios in each unit
20 for each shift for no less than 3 years. Such records
21 shall include—

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

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

1 “(i) each direct care registered nurse
2 assigned to each patient in each unit in
3 each shift; and

4 “(ii) ancillary staff who are under the
5 coordination of the direct care registered
6 nurse;

7 “(C) certification that each nurse received
8 rest and meal breaks and the identity and duty
9 hours of each direct care registered nurse who
10 provided such relief; and

11 “(D) a copy of each notice posted under
12 subsection (a).

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

16 “(A) the Secretary;

17 “(B) registered nurses and their collective
18 bargaining representatives (if any); and

19 “(C) the public under regulations estab-
20 lished by the Secretary, or in the case of a fed-
21 erally operated hospital, under section 552 of
22 title 5, United States Code (commonly known
23 as the Freedom of Information Act).

24 “(c) AUDITS.—The Secretary shall conduct periodic
25 audits to ensure—

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

3 “(2) accuracy in records maintained under this
4 section.

5 **“SEC. 3403. MINIMUM DIRECT CARE LICENSED PRACTICAL**
6 **NURSE STAFFING REQUIREMENTS.**

7 “(a) ESTABLISHMENT.—A hospital’s staffing plan
8 shall comply with minimum direct care licensed practical
9 nurse staffing requirements that the Secretary establishes
10 for units in hospitals. Such staffing requirements shall be
11 established not later than 18 months after the date of the
12 enactment of this title, and shall be based on the study
13 conducted under subsection (b).

14 “(b) STUDY.—Not later than 1 year after the date
15 of the enactment of this title, the Secretary, acting
16 through the Director of the Agency for Healthcare Re-
17 search and Quality, shall complete a study of licensed
18 practical nurse staffing and its effects on patient care in
19 hospitals. The Director may contract with a qualified enti-
20 ty or organization to carry out such study under this para-
21 graph. The Director shall consult with licensed practical
22 nurses and organizations representing licensed practical
23 nurses regarding the design and conduct of the study.

24 “(c) APPLICATION OF REGISTERED NURSE PROVI-
25 SIONS TO LICENSED PRACTICAL NURSE STAFFING RE-

1 REQUIREMENTS.—Paragraphs (2), (4)(A), (4)(B), (4)(C),
2 and (6) of section 3401(b), paragraphs (1), (2), (3), and
3 (4) of section 3401(c), and section 3402 shall apply to
4 the establishment and application of direct care licensed
5 practical nurse staffing requirements under this section
6 pursuant to the additional staffing requirements under
7 subsection (b)(3)(G) of section 3401 and in the same man-
8 ner that they apply to the establishment and application
9 of direct care registered nurse-to-patient ratios under sec-
10 tions 3401 and 3402.

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

14 “(1) 2 years after the date of the enactment of
15 this title; and

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

20 “(e) STUDY.—Not later than 1 year after the date
21 of the enactment of this title, the Secretary, acting
22 through the Director of the Agency for Healthcare Re-
23 search and Quality, shall complete a study of registered
24 and practical nurse staffing requirements in clinics and
25 other outpatient settings, and its effects on patient care

1 in outpatient settings. The Director may contract with a
2 qualified entity or organization to carry out such study
3 under this subsection. The Director shall consult with reg-
4 istered nurses and licensed practice nurses working in out-
5 patient settings, including professional nursing associa-
6 tions and labor organizations representing both registered
7 and practice nurses working in outpatient settings regard-
8 ing the design and conduct of the study.

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

10 “(a) PROFESSIONAL OBLIGATION AND RIGHTS.—All
11 nurses have a duty and right to act based on their profes-
12 sional judgment in accordance with State nursing laws
13 and regulations of the State in which the direct nursing
14 care is being performed and to provide care in the exclu-
15 sive interests of the patients and to act as the patient’s
16 advocate.

17 “(b) ACCEPTANCE OF PATIENT CARE ASSIGN-
18 MENTS.—The nurse is responsible for providing com-
19 petent, safe, therapeutic, and effective nursing care to as-
20 signed patients. Before accepting a patient assignment, a
21 nurse shall—

22 “(1) have the necessary professional knowledge,
23 judgment, skills, and ability to provide the required
24 care;

1 “(2) determine using professional judgment in
2 accordance with State nursing laws and regulations
3 of the State in which the direct nursing care is being
4 performed whether the nurse is competent to per-
5 form the nursing care required; and

6 “(3) determine whether acceptance of a patient
7 assignment would expose the patient or nurse to risk
8 of harm.

9 “(c) OBJECTION TO OR REFUSAL OF ASSIGNMENT.—
10 A nurse may object to, or refuse to participate in, any
11 activity, policy, practice, assignment, or task if in good
12 faith—

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

15 “(2) the nurse is not prepared by education,
16 training, or experience to fulfill the assignment with-
17 out compromising the safety of any patient or jeop-
18 ardizing the license of the nurse.

19 “(d) RETALIATION FOR OBJECTION TO OR REFUSAL
20 OF ASSIGNMENT BARRED.—

21 “(1) NO DISCHARGE, DISCRIMINATION, OR RE-
22 TALIATION.—No hospital shall discharge, retaliate,
23 discriminate, or otherwise take adverse action in any
24 manner with respect to any aspect of a nurse’s em-
25 ployment (as defined in section 3407), including dis-

1 charge, promotion, compensation, or terms, condi-
2 tions, or privileges of employment, based on the
3 nurse's refusal of a work assignment under sub-
4 section (c).

5 “(2) NO FILING OF COMPLAINT.—No hospital
6 shall file a complaint or a report against a nurse
7 with a State professional disciplinary agency because
8 of the nurse's refusal of a work assignment under
9 subsection (c).

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

21 “(1) Reinstatement.

22 “(2) Reimbursement of lost wages, compensa-
23 tion, and benefits.

24 “(3) Attorneys' fees.

25 “(4) Court costs.

1 “(5) Other damages.

2 “(f) COMPLAINT TO SECRETARY.—A nurse, patient,
3 collective bargaining representative, or other individual
4 may file a complaint with the Secretary against a hospital
5 that violates the provisions of this title. For any complaint
6 filed, the Secretary shall—

7 “(1) receive and investigate the complaint;

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

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

15 “(g) TOLL-FREE TELEPHONE NUMBER.—

16 “(1) IN GENERAL.—The Secretary shall provide
17 for the establishment of a toll-free telephone hotline
18 to provide information regarding the requirements
19 under sections 3401 through 3403 and to receive re-
20 ports of violations of such section.

21 “(2) NOTICE TO PATIENTS.—A hospital shall
22 provide each patient admitted to the hospital for in-
23 patient care with the hotline described in paragraph
24 (1), and shall give notice to each patient that such

1 hotline may be used to report inadequate staffing or
2 care.

3 “(h) PROTECTION FOR REPORTING.—

4 “(1) PROHIBITION ON RETALIATION OR DIS-
5 CRIMINATION.—A hospital shall not discriminate or
6 retaliate in any manner against any patient, em-
7 ployee, or contract employee of the hospital, or any
8 other individual, on the basis that such individual, in
9 good faith, individually or in conjunction with an-
10 other person or persons, has presented a grievance
11 or complaint, or has initiated or cooperated in any
12 investigation or proceeding of any governmental en-
13 tity, regulatory agency, or private accreditation
14 body, made a civil claim or demand, or filed an ac-
15 tion relating to the care, services, or conditions of
16 the hospital or of any affiliated or related facilities.

17 “(2) GOOD FAITH DEFINED.—For purposes of
18 this subsection, an individual shall be deemed to be
19 acting in good faith if the individual reasonably be-
20 lieves—

21 “(A) the information reported or disclosed
22 is true; and

23 “(B) a violation of this title has occurred
24 or may occur.

1 “(i) PROHIBITION ON INTERFERENCE
2 WITH RIGHTS.—

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

5 “(A) interfere with, restrain, or deny the
6 exercise, or attempt to exercise, by any person
7 of any right provided or protected under this
8 title; or

9 “(B) coerce or intimidate any person re-
10 garding the exercise or attempt to exercise such
11 right.

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

18 “(3) PROHIBITION ON INTERFERENCE WITH
19 PROTECTED COMMUNICATIONS.—A hospital (or an
20 individual representing a hospital) shall not make,
21 adopt, or enforce any rule, regulation, policy, or
22 practice which in any manner directly or indirectly
23 prohibits, impedes, or discourages a direct care
24 nurse from, or intimidates, coerces, or induces a di-
25 rect care nurse regarding, engaging in free speech

1 activities or disclosing information as provided under
2 this title.

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

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

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

15 “(2) includes a statement that a nurse, patient,
16 or other individual may file a complaint with the
17 Secretary against a hospital that violates the provi-
18 sions of this title; and

19 “(3) provides instructions on how to file such a
20 complaint.

21 “(k) EFFECTIVE DATE.—

22 “(1) REFUSAL; RETALIATION; CAUSE OF AC-
23 TION.—

24 “(A) IN GENERAL.—Subsections (c)
25 through (e) shall apply to objections and refus-

1 als occurring on or after the effective date of
2 the provision of this title to which the objection
3 or refusal relates.

4 “(B) EXCEPTION.—Subsection (c)(2) shall
5 not apply to objections or refusals in any hos-
6 pital before the requirements of section 3401(a)
7 or 3403(a), as applicable, apply to that hos-
8 pital.

9 “(2) PROTECTIONS FOR REPORTING.—Sub-
10 section (h)(1) shall apply to actions occurring on or
11 after the effective date of the provision to which the
12 violation relates, except that such subsection shall
13 apply to initiation, cooperation, or participation in
14 an investigation or proceeding on or after the date
15 of enactment of this title.

16 “(3) NOTICE.—Subsection (j) shall take effect
17 18 months after the date of enactment of this title.

18 **“SEC. 3405. ENFORCEMENT.**

19 “(a) IN GENERAL.—The Secretary shall enforce the
20 requirements and prohibitions of this title in accordance
21 with this section.

22 “(b) PROCEDURES FOR RECEIVING AND INVES-
23 TIGATING COMPLAINTS.—The Secretary shall establish
24 procedures under which—

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

4 “(2) such complaints shall be investigated by
5 the Secretary.

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

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

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

14 “(d) CIVIL PENALTIES.—

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

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

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

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

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

6 “(i) is employed by a hospital found
7 by the Secretary to have violated this title;
8 and

9 “(ii) knowingly violates this title, a
10 civil money penalty of not more than
11 \$20,000 for each such violation by the in-
12 dividual.

13 “(2) PROCEDURES.—The provisions of section
14 1128A of the Social Security Act (other than sub-
15 sections (a) and (b)) shall apply with respect to a
16 civil money penalty or proceeding under this sub-
17 section in the same manner as such provisions apply
18 with respect to a civil money penalty or proceeding
19 under such section 1128A.

20 “(e) PUBLIC NOTICE OF VIOLATIONS.—

21 “(1) INTERNET WEBSITE.—The Secretary shall
22 publish on the internet website of the Department of
23 Health and Human Services the names of hospitals
24 on which a civil money penalty has been imposed
25 under this section, the violation for which such pen-

1 alty was imposed, and such additional information
2 as the Secretary determines appropriate.

3 “(2) CHANGE OF OWNERSHIP.—With respect to
4 a hospital that had a change of ownership, as deter-
5 mined by the Secretary, penalties imposed on the
6 hospital while under previous ownership shall no
7 longer be published by the Secretary pursuant to
8 paragraph (1) after the 1-year period beginning on
9 the date of change of ownership.

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

13 **“SEC. 3406. DEFINITIONS.**

14 “For purposes of this title:

15 “(1) ACUITY LEVEL.—The term ‘acuity level’
16 means the determination, using a hospital acuity
17 measurement tool that has been developed and es-
18 tablished in coordination with direct care registered
19 nurses and made transparent pursuant to section
20 3401(c)(4), of nursing care requirements, based on
21 the assigned direct care registered nurse’s profes-
22 sional judgment of—

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

1 “(B) the need for specialized equipment;
2 and

3 “(C) the intensity of nursing interventions
4 required.

5 “(2) COMPETENCE.—The term ‘competence’ or
6 ‘competent’ means the satisfactory application of the
7 duties and responsibilities of a registered nurse in
8 providing nursing care to specific patient popu-
9 lations and for acuity levels for each patient care
10 unit or area pursuant to the State nursing laws and
11 regulations of the State in which the direct nursing
12 care is being performed.

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

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

1 “(5) EMPLOYMENT.—The term ‘employment’
2 includes the provision of services under a contract or
3 other arrangement.

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

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

11 “(8) NURSING CARE PLAN.—The term ‘nursing
12 care plan’ means a plan developed by the assigned
13 direct care registered nurse (in accordance with
14 nursing law in the State in which the nursing care
15 is performed) that indicates the nursing care to be
16 given to individual patients that—

17 “(A) considers the acuity level of the pa-
18 tient;

19 “(B) is developed in coordination with the
20 patient, the patient’s family, or other represent-
21 atives when appropriate, and staff of other dis-
22 ciplines involved in the care of the patient;

23 “(C) reflects all elements of the nursing
24 process; and

1 “(D) recommends the number and skill
2 mix of additional licensed and unlicensed direct
3 care staff needed to fully implement the nursing
4 care plan.

5 “(9) PROFESSIONAL JUDGMENT.—The term
6 ‘professional judgment’ means, in accordance with
7 State nursing laws and regulations of the State in
8 which the direct nursing care is being performed, the
9 direct care registered nurse’s application of knowl-
10 edge, expertise, and experience in conducting a com-
11 prehensive nursing assessment of each patient and
12 in making independent decisions about patient care
13 including the need for additional staff.

14 “(10) STAFFING PLAN.—The term ‘staffing
15 plan’ means a staffing plan required under section
16 3401.

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

19 “(A) means a state of emergency that is
20 an unpredictable or unavoidable occurrence at
21 an unscheduled or unpredictable interval, relat-
22 ing to health care delivery and requiring imme-
23 diate medical interventions and care; and

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

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

5 “Nothing in this title shall be construed to authorize
6 disclosure of private and confidential patient information,
7 if such disclosure is not authorized or required by other
8 applicable law.”.

9 (b) RECOMMENDATIONS TO CONGRESS.—Not later
10 than 1 year after the date of enactment of this Act, the
11 Secretary of Health and Human Services shall submit to
12 Congress a report containing recommendations for ensur-
13 ing that sufficient numbers of nurses are available to meet
14 the requirements imposed by title XXXIV of the Public
15 Health Service Act, as added by subsection (a).

16 (c) REPORT BY HRSA.—

17 (1) IN GENERAL.—Not later than 2 years after
18 the date of enactment of this Act, the Administrator
19 of the Health Resources and Services Administra-
20 tion, in consultation with the National Health Care
21 Workforce Commission, shall submit to Congress a
22 report regarding the relationship between nurse
23 staffing levels and nurse retention in hospitals.

24 (2) UPDATED REPORT.—Not later than 5 years
25 after the date of enactment of this Act, the Adminis-

1 trator of the Health Resources and Services Admin-
2 istration, in consultation with the National Health
3 Care Workforce Commission, shall submit to Con-
4 gress an update of the report submitted under para-
5 graph (1).

6 (d) ENFORCEMENT OF REQUIREMENTS THROUGH
7 FEDERAL PROGRAMS.—

8 (1) MEDICARE PROGRAM.—Section 1866(a)(1)
9 of the Social Security Act (42 U.S.C. 1395cc(a)(1))
10 is amended—

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

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

15 (C) by inserting after subparagraph (Y)
16 the following new subparagraph:

17 “(Z) in the case of a hospital, to comply
18 with the provisions of title XXXIV of the Public
19 Health Service Act.”.

20 (2) MEDICAID PROGRAM.—Section 1902(a) of
21 the Social Security Act (42 U.S.C. 1396a(a)) is
22 amended—

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

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

3 (C) by inserting after paragraph (83) the
4 following new paragraph:

5 “(84) provide that any hospital that receives a
6 payment under such plan comply with the provisions
7 of title XXXIV of the Public Health Service Act (re-
8 lating to minimum direct care registered nurse staff-
9 ing requirements).”.

10 (e) NURSING HOMES.—No later than one year after
11 enactment of this Act, the Secretary of Health and
12 Human Services shall promulgate a rule for minimum
13 staffing standards for skilled nursing facilities under the
14 Medicare program and for nursing facilities under the
15 Medicaid program that align with the standards set in this
16 section.

17 **SEC. 133. ENHANCEMENTS FOR REDUCED COST-SHARING.**

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

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

23 (2) by amending subsection (c)(1)(B) to read as
24 follows:

1 “(B) COORDINATION WITH ACTUARIAL
2 LIMITS.—The Secretary shall ensure the reduc-
3 tion under this paragraph shall not result in the
4 plan’s share of the total allowed costs of bene-
5 fits provided under the plan becoming less
6 than—

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

9 “(ii) 90 percent in the case of an eli-
10 gible insured described in paragraph
11 (2)(B); and

12 “(iii) 85 percent in the case of an eli-
13 gible insured described in paragraph
14 (2)(C).”; and

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

17 “(2) ADDITIONAL REDUCTION.—The Secretary
18 shall establish procedures under which the issuer of
19 a qualified health plan to which this section applies
20 shall further reduce cost-sharing under the plan in
21 a manner sufficient to—

22 “(A) in the case of an eligible insured
23 whose household income is not less than 100
24 percent but not more than 200 percent of the
25 poverty line for a family of the size involved, in-

1 crease the plan’s share of the total allowed
2 costs of benefits provided under the plan to 95
3 percent of such costs;

4 “(B) in the case of an eligible insured
5 whose household income is more than 200 per-
6 cent but not more than 300 percent of the pov-
7 erty line for a family of the size involved, in-
8 crease the plan’s share of the total allowed
9 costs of benefits provided under the plan to 90
10 percent of such costs; and

11 “(C) in the case of an eligible insured
12 whose household income is more than 300 per-
13 cent but not more than 400 percent of the pov-
14 erty line for a family of the size involved, in-
15 crease the plan’s share of the total allowed
16 costs of benefits provided under the plan to 85
17 percent of such costs.”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 this subsection shall apply to plan years beginning after
20 December 31, 2028.

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

24 “(g) FUNDING.—Out of any funds in the Treasury
25 not otherwise appropriated, there are appropriated to the

1 Secretary such sums as may be necessary for payments
2 under this section.”.

3 **SEC. 134. REPEAL OF BONUS PAYMENTS FOR MEDICARE**
4 **ADVANTAGE PLANS.**

5 Section 1853(o) of the Social Security Act (42 U.S.C.
6 1395w–23(o)) is repealed.

7 **TITLE II—TAX PROVISIONS**

8 **SEC. 201. SUNSET OF PUBLIC LAWS 115–97 AND 119–21.**

9 (a) IN GENERAL.—All provisions of, and amend-
10 ments made by, Public Law 115–97 and Public Law 119–
11 21 shall not apply to calendar, taxable, plan, or limitation
12 years beginning after December 31, 2027.

13 (b) APPLICATION OF CERTAIN LAWS.—The Internal
14 Revenue Code of 1986 shall be applied and administered
15 to years described in subsection (a) as if the provisions
16 and amendments described in subsection (a) had never
17 been enacted.

18 **SEC. 202. SURTAX.**

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

22 **SEC. 203. BASIS OF PROPERTY ACQUIRED FROM A DECE-**
23 **DENT.**

24 (a) IN GENERAL.—Section 1014 of the Internal Rev-
25 enue Code of 1986 is amended by striking “person, be”

1 and all that follows through the period at the end and
2 inserting the following: “person, be the basis in the hands
3 of the decedent.”.

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

7 **SEC. 204. MEDICARE PAYROLL TAX.**

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

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

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

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

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

1 **SEC. 206. TERMINATION OF DEDUCTION FOR CONTRIBU-**
2 **TIONS TO HEALTH SAVINGS ACCOUNTS.**

3 Section 223(b) of the Internal Revenue Code of 1986
4 is amended by adding at the end the following new para-
5 graph:

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

10 **SEC. 207. INCREASE IN EXCISE TAX ON SMALL CIGARS AND**
11 **CIGARETTES AND OTHER TOBACCO PROD-**
12 **UCTS.**

13 (a) **SMALL CIGARS.**—Section 5701(a)(1) of the Inter-
14 nal Revenue Code of 1986 is amended by striking
15 “\$50.33” and inserting “\$100.66”.

16 (b) **CIGARETTES.**—Section 5701(b) of such Code is
17 amended—

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

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

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

1 (d) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of
2 such Code is amended by striking “\$24.78” and inserting
3 “\$49.56”.

4 (e) LARGE CIGARS.—Paragraph (2) of section
5 5701(a) of the Internal Revenue Code of 1986 is amended
6 by striking “52.75 percent” and all that follows through
7 the period and inserting “\$24.78 per pound (and a propor-
8 tionate tax at the like rate on all fractional parts of a
9 pound) but not less than 5.033 cents per cigar.”.

10 (f) SMOKELESS TOBACCO.—

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

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

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

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

18 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
19 SINGLE-USE UNITS.—On discrete single-use units,
20 \$107.65 per each 1,000 single-use units.”.

21 (2) DISCRETE SINGLE-USE UNIT.—Section
22 5702(m) of such Code is amended—

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

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

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

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

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

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

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

13 (a) DISTILLED SPIRITS.—Section 5001(a)(1) of the
14 Internal Revenue Code of 1986 is amended by striking
15 “\$13.50” and inserting “\$16.00”.

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

19 (2) Section 5041(b)(2) of the Internal Revenue
20 Code of 1986 is amended by striking “\$1.57 per
21 wine gallon” and inserting “\$16.00 per proof gal-
22 lon”.

23 (3) Section 5041(b)(3) of the Internal Revenue
24 Code of 1986 is amended by striking “\$3.15 per

1 wine gallon” and inserting “\$16.00 per proof gal-
2 lon”.

3 (4) Section 5041(b)(4) of the Internal Revenue
4 Code of 1986 is amended by striking “\$3.40 per
5 wine gallon” and inserting “\$16.00 per proof gal-
6 lon”.

7 (5) Section 5041(b)(5) of the Internal Revenue
8 Code of 1986 is amended by striking “\$3.30 per
9 wine gallon” and inserting “\$16.00 per proof gal-
10 lon”.

11 (6) Section 5041(b)(3) of the Internal Revenue
12 Code of 1986 is amended by striking “\$22.6 cents
13 per wine gallon” and inserting “\$16.00 per proof
14 gallon”.

15 (c) BEER.—Section 5051(B) of the Internal Revenue
16 Code of 1986 is amended by striking “\$18 for per barrel”
17 and inserting “\$16 per proof gallon”.

18 **SEC. 209. TAX ON SUGARED DRINKS.**

19 (a) IN GENERAL.—Subchapter D of chapter 32 of the
20 Internal Revenue Code of 1986 is amended by inserting
21 after part I the following new part:

22 **“PART II—SUGAR-SWEETENED BEVERAGES**

“Sec. 4171. Imposition of tax.

“Sec. 4172. Definitions.

“Sec. 4173. Special rules.

1 **“SEC. 4171. IMPOSITION OF TAX.**

2 “(a) IN GENERAL.—There is hereby imposed a tax
3 on the sale or transfer of any specified sugar-sweetened
4 beverage product by the manufacturer, producer, or im-
5 porter thereof.

6 “(b) RATE OF TAX.—The rate of tax imposed under
7 subsection (a) shall be equal to one cent per 4.2 grams
8 of caloric sweetener contained in such specified sugar-
9 sweetened beverage product.

10 “(c) PERSONS LIABLE FOR TAX.—The manufac-
11 turer, producer, or importer referred to in subsection (a)
12 shall be liable for the tax imposed by such subsection.

13 **“SEC. 4172. DEFINITIONS.**

14 “(a) SPECIFIED SUGAR-SWEETENED BEVERAGE
15 PRODUCT.—For purposes of this part—

16 “(1) IN GENERAL.—For purposes of this part,
17 the term ‘specified sugar-sweetened beverage prod-
18 uct’ means—

19 “(A) any liquid intended for human con-
20 sumption which contains a caloric sweetener,
21 and

22 “(B) any liquid, or solid mixture of ingre-
23 dients, which—

24 “(i) contains a caloric sweetener, and

1 “(ii) is intended for use as an ingre-
2 dient in a liquid described in subparagraph
3 (A).

4 “(2) EXCEPTIONS.—The following shall not be
5 treated as liquids described in paragraph (1)(A):

6 “(A) Any liquid the primary ingredients of
7 which are milk or soy, rice, or similar plant-
8 based milk substitute.

9 “(B) Any liquid composed entirely of one
10 or more of the following:

11 “(i) The original liquid resulting from
12 the pressing of fruit or vegetables.

13 “(ii) The liquid resulting from the re-
14 constitution of fruit or vegetable juice con-
15 centrate.

16 “(iii) The liquid resulting from the
17 restoration of water to dehydrated fruit or
18 vegetable juice.

19 “(C) Infant formula.

20 “(D) Any liquid products manufactured for
21 use as—

22 “(i) an oral nutritional therapy for
23 persons who cannot absorb or metabolize
24 dietary nutrients from food or beverages,

1 “(ii) a source of necessary nutrition
2 used due to a medical condition, or

3 “(iii) an oral electrolyte solution for
4 infants and children formulated to prevent
5 dehydration due to illness.

6 “(E) Any liquid with respect to which tax
7 is imposed under chapter 51 (relating to dis-
8 tilled spirits, wines, and beer) or under section
9 7652 by reason of the tax imposed under chap-
10 ter 51 being imposed on like articles of domes-
11 tic manufacture.

12 “(b) CALORIC SWEETENER.—For purposes of this
13 part, the term ‘caloric sweetener’ means monosaccharides,
14 disaccharides, and high-fructose corn syrup.

15 **“SEC. 4173. SPECIAL RULES.**

16 “(a) SWEETENER TAXED ONLY ONCE.—In the case
17 of any specified sugar-sweetened beverage product which
18 is manufactured or produced by including one or more
19 other specified sugar-sweetened beverage products, no tax
20 shall be imposed under this section on any caloric sweet-
21 ener contained in the resulting specified sugar-sweetened
22 beverage product if tax was previously imposed under this
23 section on such caloric sweetener when contained in the
24 specified sugar-sweetened beverage product so included.

1 “(b) INFLATION ADJUSTMENT.—In the case of any
2 sale after December 31, 2015, the one cent amount in sec-
3 tion 4171(b) shall be increased by an amount equal to—

4 “(1) such amount, multiplied by

5 “(2) the cost-of-living adjustment determined
6 under section 1(f)(3) for the calendar year in which
7 such sale occurs, determined by substituting ‘cal-
8 endar year 2014’ for ‘calendar year 1992’ in sub-
9 paragraph (B) thereof.

10 Any increase determined under this subsection shall
11 be rounded to the nearest multiple of one-tenth of
12 a cent.”.

13 (b) CONFORMING AMENDMENTS.—

14 (1) Section 4221(a) is amended by adding at
15 the end the following: “Paragraphs (1), (4), (5), and
16 (6) shall not apply to the tax imposed under section
17 4171.”.

18 (2) The table of parts for subchapter D of
19 chapter 32 of such Code is amended by inserting
20 after the item relating to part I the following new
21 item:

22 “Part II—Sugar-Sweetened Beverages”.

23 (c) EFFECTIVE DATE.—

24 (1) IN GENERAL.—Except as provided in para-
25 graph (2), the amendments made by this section

1 shall take effect on the date of the enactment of this
2 Act.

3 (2) EXCISE TAX.—The amendments made by
4 subsections (a) and (b) shall apply to sales after the
5 date of the enactment of this Act.

6 **SEC. 210. REPEAL OF EXCISE TAX ON HIGH-COST EM-**
7 **PLOYER-SPONSORED HEALTH COVERAGE.**

8 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
9 enue Code of 1986 is amended by striking section 4980I.

10 (b) CONFORMING AMENDMENT.—Section 6051 of
11 such Code is amended—

12 (1) in paragraph (14) of subsection (a), by
13 striking “section 4980I(d)(1)” and inserting “sub-
14 section (g)”, and

15 (2) by adding at the end the following:

16 “(g) APPLICABLE EMPLOYER-SPONSORED COV-
17 ERAGE.—For purposes of subsection (a)(14)—

18 “(1) IN GENERAL.—The term ‘applicable em-
19 ployer-sponsored coverage’ means, with respect to
20 any employee, coverage under any group health plan
21 made available to the employee by an employer
22 which is excludable from the employee’s gross in-
23 come under section 106, or would be so excludable
24 if it were employer-provided coverage (within the
25 meaning of such section 106).

1 “(2) EXCEPTIONS.—The term ‘applicable em-
2 ployer-sponsored coverage’ shall not include—

3 “(A) any coverage (whether through insur-
4 ance or otherwise) described in section
5 9832(c)(1) (other than subparagraph (G) there-
6 of) or for long-term care;

7 “(B) any coverage under a separate policy,
8 certificate, or contract of insurance which pro-
9 vides benefits substantially all of which are for
10 treatment of the mouth (including any organ or
11 structure within the mouth) or for treatment of
12 the eye; or

13 “(C) any coverage described in section
14 9832(c)(3) the payment for which is not exclud-
15 able from gross income and for which a deduc-
16 tion under section 162(l) is not allowable.

17 “(3) COVERAGE INCLUDES EMPLOYEE PAID
18 PORTION.—Coverage shall be treated as applicable
19 employer-sponsored coverage without regard to
20 whether the employer or employee pays for the cov-
21 erage.

22 “(4) GOVERNMENTAL PLANS INCLUDED.—Ap-
23 plicable employer-sponsored coverage shall include
24 coverage under any group health plan established
25 and maintained primarily for its civilian employees

1 by the Government of the United States, by the gov-
2 ernment of any State or political subdivision thereof,
3 or by any agency or instrumentality of any such gov-
4 ernment.

5 “(5) COST OF COVERAGE.—

6 “(A) HEALTH FSAS.—In the case of appli-
7 cable employer-sponsored coverage consisting of
8 coverage under a flexible spending arrangement
9 (as defined in section 2205(g)), the cost of the
10 coverage shall be equal to the amount deter-
11 mined under rules similar to the rules of section
12 4980B(f)(4) with respect to any reimbursement
13 under the arrangement reduced by the contribu-
14 tions described in subsection (a)(14)(B).

15 “(B) ARCHER MSAS AND HSAS.—In the
16 case of applicable employer-sponsored coverage
17 consisting of coverage under an arrangement
18 under which the employer makes contributions
19 described in subsection (b) or (d) of section
20 106, the cost of the coverage shall be equal to
21 the amount of employer contributions under the
22 arrangement until the termination of HSAs as
23 described under section 206 of such Act.

24 “(C) ALLOCATION ON A MONTHLY
25 BASIS.—If cost is determined on other than a

1 monthly basis, the cost shall be allocated to
2 months in a taxable period on such basis as the
3 Secretary may prescribe.”.

4 (c) CLERICAL AMENDMENT.—The table of sections
5 for chapter 43 of such Code is amended by striking the
6 item relating to section 4980I.

7 (d) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to taxable years beginning after
9 December 31, 2026.

10 **TITLE III—DRUG-RELATED** 11 **PROVISIONS**

12 **SEC. 301. ESTABLISHMENT OF THE PRESCRIPTION DRUG** 13 **AND MEDICAL DEVICE REVIEW BOARD.**

14 There is established in the Department of Health and
15 Human Services a board to be known as the Prescription
16 Drug and Medical Device Price Review Board (in this Act
17 referred to as the “Board”).

18 **SEC. 302. MEMBERSHIP; STAFF.**

19 (a) MEMBERS.—The Board shall be composed of the
20 members as follows:

21 (1) The Assistant Secretary for Planning and
22 Evaluation of the Department of Health and Human
23 Services (or the Assistant Secretary’s designee).

24 (2) The Administrator of the Centers for Medi-
25 care & Medicaid Services or, beginning with 2028,

1 the Administrator of the Center for Health Care (or
2 the Administrator's designee).

3 (3) The Assistant Director for the Health Serv-
4 ices Division of the Federal Bureau of Prisons (or
5 the Assistant Director's designee).

6 (4) The Secretary of Defense (or the Sec-
7 retary's designee).

8 (5) The Secretary of Veterans Affairs (or the
9 Secretary's designee).

10 (6) The Commissioner of Food and Drugs (or
11 the Commissioner's designee).

12 (7) The Director of the National Institutes of
13 Health (or the Director's designee).

14 (b) CHAIRPERSON.—The Board shall designate 1
15 member of the Board to serve as the chairperson.

16 (c) DIRECTOR AND STAFF.—

17 (1) DIRECTOR.—The Board shall have a direc-
18 tor who shall be appointed by the chairperson of the
19 Board, subject to rules prescribed by the Board.

20 (2) STAFF.—The director may appoint and fix
21 the pay of such additional personnel as the chair-
22 person considers appropriate, subject to rules pre-
23 scribed by the Board.

24 (3) APPLICABILITY OF CERTAIN CIVIL SERVICE
25 LAWS.—The director and staff of the Board shall be

1 appointed subject to the provisions of title 5, United
2 States Code, governing appointments in the competi-
3 tive service, and shall be paid in accordance with the
4 requirements of chapter 51 and subchapter III of
5 chapter 53 of such title relating to classification and
6 General Schedule pay rates; except that an indi-
7 vidual so appointed may not receive pay in excess of
8 the maximum annual rate of basic pay payable for
9 grade GS-15 of the General Schedule.

10 (d) ASSISTANCE FOR THE BOARD.—Subject to sec-
11 tion 306(g), in carrying out this title, the Board—

12 (1) may seek assistance from outside experts in
13 the fields of consumer advocacy, medicine, pharma-
14 cology, pharmacy, and prescription drug reimburse-
15 ment; and

16 (2) shall establish and maintain an advisory
17 group and a stakeholder group for purposes of seek-
18 ing such assistance.

19 (e) INITIAL MEETING.—The Board shall hold its ini-
20 tial meeting not later than 90 days after the date of the
21 enactment of this Act.

22 (f) BANNED INDIVIDUALS.—

23 (1) DRUG COMPANY LOBBYISTS.—No former
24 registered drug manufacturer lobbyist—

1 (A) may be appointed to the position of
2 Director of the Office; or

3 (B) may be employed by the Office during
4 the 6-year period beginning on the date on
5 which the registered lobbyist terminates its reg-
6 istration in accordance with section 4(d) of the
7 Lobbying Disclosure Act of 1995 (2 U.S.C.
8 1603(d)) or the agent terminates its status, as
9 applicable.

10 (2) SENIOR EXECUTIVES OF LAW-BREAKING
11 COMPANIES.—No former senior executive of a cov-
12 ered entity—

13 (A) may be appointed to the position of
14 Director of the Office; or

15 (B) may be employed by the Office during
16 the 6-year period beginning on the later of—

17 (i) the date of the settlement; and

18 (ii) the date on which the enforcement
19 action has concluded.

20 (3) COVERED ENTITY.—The term “covered en-
21 tity” means any entity that is—

22 (A) a drug manufacturer; and

23 (B)(i) operating under Federal settlement,
24 including a Federal consent decree; or

1 (ii) the subject of an enforcement ac-
2 tion in a court of the United States or by
3 an agency.

4 **SEC. 303. PROHIBITION AGAINST EXCESSIVE PRICE.**

5 (a) PROHIBITION.—Beginning on the effective date
6 of the regulation required by subsection (b), the manufac-
7 turer of a prescription drug or medical device shall not
8 charge an excessive price, as determined pursuant to such
9 regulation, for such drug or device.

10 (b) FORMULA.—The Board shall by regulation pre-
11 scribe a formula for determining whether the average
12 manufacturer price of such drug or device over an annual
13 quarter is an excessive price.

14 (c) DETERMINATION OF EXCESSIVE PRICE.—If the
15 Board determines, on its own initiative or in response to
16 a petition submitted under subsection (d), that the manu-
17 facturer of a prescription drug or medical device charges
18 an excessive price for such drug or device in violation of
19 subsection (a)—

20 (1) the Board shall give the manufacturer—

21 (A) notice of such violation; and

22 (B) subject to subsection (d), a period to
23 correct such violation; and

24 (2) if the manufacturer fails to correct the vio-
25 lation by the end of such period, the manufacturer

1 shall be subject to section 304, section
2 1927(c)(2)(E) of the Social Security Act (as added
3 by subsection (c) of section 304), and section 4192
4 of the Internal Revenue Code of 1986, as added by
5 subsection (d) of section 304.

6 (d) PETITIONS.—Any person may petition the Board
7 to make a determination under subsection (c) regarding
8 the pricing of a prescription drug or medical device. Not
9 later than 90 days after the date of receipt of such a peti-
10 tion, the Board shall—

11 (1) make a determination under subsection (c)
12 regarding such pricing; or

13 (2) decline to make such a determination.

14 (e) CONTINUING VIOLATION.—The Board shall not
15 be required to give a manufacturer an opportunity to cor-
16 rect a violation, as described in subsection (c)(1)(B), be-
17 fore the manufacturer becomes subject to the provisions
18 described in subsection (c)(2) for such violation, if—

19 (1) the Board has already provided such an op-
20 portunity to correct to the manufacturer; and

21 (2) the Board finds that the violation of sub-
22 section (a) is a continuation of an earlier violation
23 with respect to which such an opportunity was pro-
24 vided.

1 (f) CONSIDERATIONS.—The formula required by sub-
2 section (a) shall at a minimum take into consideration—

3 (1) the average manufacturer price of the pre-
4 scription drug or medical device over the respective
5 annual quarter or quarters;

6 (2) the average manufacturer price of other
7 prescription drugs or medical devices in the same
8 therapeutic class over the same quarter or quarters;

9 (3) the average price at which the prescription
10 drug or medical device and other prescription drugs
11 and medical devices in the same therapeutic class
12 have been sold by manufacturers in countries other
13 than the United States;

14 (4) the costs associated with producing and
15 marketing the prescription drug or medical device,
16 the value of the drug or device to patients where suf-
17 ficient data is available to determine such value, the
18 total Federal investment in the development of the
19 drug or device, the size of the patient population re-
20 ceiving the drug or device, and other factors deter-
21 minative as to the true cost of production; and

22 (5) whether the price of the prescription drug
23 or medical device increased during any annual quar-
24 ter by a percentage that is more than 2 percent
25 greater than the CPI increase percentage (as defined

1 in section 215(i) of the Social Security Act (42
2 U.S.C. 415)) for the respective annual quarter.

3 (g) VALUE OR COST-EFFECTIVENESS ASSESS-
4 MENTS.—The use of Quality-Adjusted Life Years, Dis-
5 ability-Adjusted Life Years, or other similar mechanisms
6 is prohibited for use in value or cost-effectiveness assess-
7 ments for purposes of this section.

8 **SEC. 304. ENFORCEMENT PROVISIONS.**

9 (a) REDUCED PATENT TERM.—If the Board finds
10 that the manufacturer of a prescription drug or medical
11 device, who is also an owner of a patent for such drug
12 or device, charged an excessive price for such drug or de-
13 vice in violation of section 303(a), the Board may—

14 (1) reduce the term, by not more than 5 years,
15 of any patent issued under title 35, United States
16 Code, relating to such drug or device; or

17 (2) if the term of each patent for such drug or
18 device has expired, reduce the term, by not more
19 than 5 years, of another patent owned by the patent
20 owner relating to a prescription drug or medical de-
21 vice.

22 (b) CIVIL PENALTIES.—If the Board determines
23 under section 303(c) that a manufacturer of a prescription
24 drug or medical device charged an excessive price for a
25 prescription drug or medical device in violation of section

1 303(a), the Board may impose a civil penalty on the man-
2 ufacturer of not more than 10 percent of the manufactur-
3 er's gross sales of the drug or device during the period
4 beginning on the date on which an excessive price is first
5 charged and ending on the date on which the manufac-
6 turer ceases to charge an excessive price.

7 (c) TAX ON EXCESS PRESCRIPTION DRUG AND MED-
8 ICAL DEVICE PROFITS.—

9 (1) DETERMINATION OF AMOUNT.—If the
10 Board determines under section 303(a) that a man-
11 ufacturer, producer, or importer of a prescription
12 drug or medical device charged an excessive price for
13 such prescription drug or medical device during a
14 taxable year, the Board may determine under this
15 paragraph a reasonable price for such drug or device
16 for such taxable year.

17 (2) IMPOSITION OF TAX.—

18 (A) IN GENERAL.—The Internal Revenue
19 Code of 1986 is amended by inserting after sec-
20 tion 4191 the following new section:

21 **“SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL**
22 **DEVICE PRICE.**

23 **“(a) IN GENERAL.—**There is hereby imposed on the
24 sale of any prescription drug or medical device by the
25 manufacturer, producer, or importer a tax equal to the

1 difference between the price at which such drug or device
2 is so sold and the reasonable price determined by the Pre-
3 scription Drug and Medical Device Price Review Board
4 under section 303(c)(1) of the Medicare for America Act
5 for such drug or device for the taxable year for sales after
6 the determination.

7 “(b) PRESCRIPTION DRUG OR MEDICAL DEVICE.—
8 For purposes of this section, the term ‘prescription drug
9 or medical device’ means any prescription drug (as defined
10 in section 9008 of the Patient Protection and Affordable
11 Care Act) or device (as defined in section 201(h) of the
12 Federal Food, Drug, and Cosmetic Act) intended for hu-
13 mans.”.

14 (B) CLERICAL AMENDMENT.—The table of
15 parts for chapter 32 of such Code is amended—

16 (i) in the item relating to subchapter
17 E, by striking “Medical” and inserting
18 “Drugs and medical”; and

19 (ii) by inserting after the item relating
20 to section 4191 the following new item:

21 **“SEC. 4192. EXCESSIVE PRESCRIPTION DRUG AND MEDICAL**
22 **DEVICE PRICE.”.**

23 (3) EFFECTIVE DATE.—This subsection and the
24 amendments made by this subsection shall apply
25 with respect to sales after December 31, 2028.

1 **SEC. 305. AUTHORITY.**

2 (a) **OBTAINING OFFICIAL DATA.**—The chairperson of
3 the Board may secure directly from any Federal agency
4 information necessary to enable the Board to carry out
5 its duties. Upon request of the chairperson, the head of
6 the agency shall furnish such information to the Board
7 to the extent such information is not prohibited from dis-
8 closure by law.

9 (b) **MAILS.**—The Board may use the United States
10 mails in the same manner and under the same conditions
11 as other Federal agencies.

12 (c) **ADMINISTRATIVE SUPPORT SERVICES.**—Upon the
13 request of the chairperson of the Board, the Administrator
14 of General Services shall provide to the Board, on a reim-
15 bursable basis, the administrative support services nec-
16 essary for the Board to carry out its duties.

17 (d) **CONTRACT AUTHORITY.**—The Board may con-
18 tract with and compensate government and private agen-
19 cies or persons for the purpose of conducting research,
20 surveys, and other services necessary to enable the Board
21 to carry out its duties.

22 (e) **INVESTIGATIONS.**—The Board may make such in-
23 vestigations as it considers necessary to determine whether
24 there is or may be a violation of any regulation promul-
25 gated under this Act and may require or permit any per-
26 son to file with it a statement in writing, under oath or

1 otherwise as the Board shall determine, as to all the facts
2 and circumstances concerning the matter to be inves-
3 tigated.

4 (f) SUBPOENA POWER.—

5 (1) IN GENERAL.—The Board may issue sub-
6 poenas requiring the attendance and testimony of
7 witnesses and the production of any evidence relat-
8 ing to any matter under investigation by the Board.
9 The attendance of witnesses and the production of
10 evidence may be required from any place within the
11 United States at any designated place of hearing
12 within the United States.

13 (2) FAILURE TO OBEY A SUBPOENA.—If a per-
14 son refuses to obey a subpoena issued under para-
15 graph (1), the Board may apply to a United States
16 district court for an order requiring that person to
17 appear before the Board to give testimony, produce
18 evidence, or both, relating to the matter under inves-
19 tigation. The application may be made within the ju-
20 dicial district where the hearing is conducted or
21 where that person is found, resides, or transacts
22 business. Any failure to obey the order of the court
23 may be punished by the court as civil contempt.

24 (3) SERVICE OF SUBPOENAS.—The subpoenas
25 of the Board shall be served in the manner provided

1 for subpoenas issued by a United States district
2 court under the Federal Rules of Civil Procedure for
3 the United States district courts.

4 (4) SERVICE OF PROCESS.—All process of any
5 court to which application is made under paragraph
6 (2) may be served in the judicial district in which
7 the person required to be served resides or may be
8 found.

9 (5) NOTICE.—Upon issuing any subpoena
10 under this subsection, the Board shall give notice of
11 such issuance to the appropriate committees of Con-
12 gress, including the Committee on Appropriations of
13 the House of Representatives and the Committee on
14 Appropriations of the Senate.

15 (g) CONFIDENTIALITY.—Under this title, the Sec-
16 retary shall enforce applicable law concerning a trade se-
17 cret or confidential information subject to section
18 552(b)(4) of title 5, United States Code, or section 1905
19 of title 18.

20 **SEC. 306. REGULATIONS.**

21 (a) IN GENERAL.—Not later than 1 year after the
22 date of the initial meeting held under section 302(e), the
23 Board shall issue final regulations to carry out this Act.

24 (b) NOTICE AND COMMENT REQUIREMENT.—The
25 regulations developed under subsection (a) shall be issued

1 in accordance with the notice and comment procedures es-
2 tablished under section 553 of title 5, United States Code.

3 **SEC. 307. REPORT TO FEDERAL AGENCIES.**

4 Not later than 1 year after the effective date of the
5 regulations under section 306 and annually thereafter, the
6 Board shall submit to each Federal agency that dispenses
7 or makes payments for the dispensing of prescription
8 drugs or medical devices a report containing a list of each
9 prescription drug and medical device for which an exces-
10 sive price was charged during the preceding calendar year,
11 as determined by the Board under section 303. The Sec-
12 retary shall make this report publicly available.

13 **SEC. 308. DEFINITIONS.**

14 In this title:

15 (1) **AFFILIATE.**—The term “affiliate” means,
16 with respect to a manufacturer, any entity that con-
17 trols, is controlled by, or is under common control
18 with such manufacturer.

19 (2) **AVERAGE MANUFACTURER PRICE.**—The
20 term “average manufacturer price” means the aver-
21 age price charged by the manufacturer of a prescrip-
22 tion drug or medical device, as applicable, for sales
23 of the drug or device by the manufacturer in the
24 United States over the respective annual quarter.

1 (3) MEDICAL DEVICE.—The term “medical de-
2 vice” means a device (as defined in section 201 of
3 the Federal Food, Drug, and Cosmetic Act (21
4 U.S.C. 321)).

5 (4) PRESCRIPTION DRUG.—The term “prescrip-
6 tion drug” means a drug (as defined in section 201
7 of the Federal Food, Drug, and Cosmetic Act (21
8 U.S.C. 321)) that is subject to section 503(b)(1) of
9 such Act (21 U.S.C. 353(b)(1)).

10 (5) MANUFACTURER.—The term “manufac-
11 turer” means the person—

12 (A) that holds the application for a drug
13 approved under section 505 of the Federal
14 Food, Drug, and Cosmetic Act or the license
15 issued under section 351 of the Public Health
16 Service Act; or

17 (B) who is responsible for setting the price
18 for the drug.

19 (6) WHOLESALE ACQUISITION COST.—The term
20 “wholesale acquisition cost” has the meaning given
21 that term in section 1847A(c)(6)(B) of the Social
22 Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

1 **SEC. 309. MORATORIUM ON DIRECT-TO-CONSUMER DRUG**
2 **ADVERTISING.**

3 The Federal Food, Drug, and Cosmetic Act (21
4 U.S.C. 301 et seq.) is amended—

5 (1) in section 301 (21 U.S.C. 331), by adding
6 at the end the following:

7 “(eee) The conduct of direct-to-consumer advertising
8 of a drug in violation of section 506J.”; and”.

9 (2) in chapter V, by inserting after section 506I
10 (21 U.S.C. 356f) the following:

11 **“SEC. 506J. DIRECT-TO-CONSUMER DRUG ADVERTISING.**

12 **“(a) PROHIBITIONS.—**

13 **“(1) FIRST THREE YEARS.—**

14 **“(A) IN GENERAL.—**Subject to subpara-
15 graph (B), no person shall conduct direct-to-
16 consumer advertising of a drug for which an
17 application is submitted under section 505(b)
18 before the end of the 3-year period beginning
19 on the date of the approval of such application.

20 **“(B) WAIVER.—**The Secretary may waive
21 the application of subparagraph (A) to a drug
22 during the third year of the 3-year period de-
23 scribed in such subparagraph if—

24 **“(i)** the sponsor of the drug submits
25 an application to the Secretary pursuant to
26 subparagraph (C); and

1 “(ii) the Secretary, after considering
2 the application and any accompanying ma-
3 terials, determines that direct-to-consumer
4 advertising of the drug would have an af-
5 firmative value to public health.

6 “(C) APPLICATION FOR WAIVER.—To seek
7 a waiver under subparagraph (B), the sponsor
8 of a drug shall submit an application to the
9 Secretary at such time, in such manner, and
10 containing such information as the Secretary
11 may require.

12 “(2) SUBSEQUENT YEARS.—The Secretary may
13 prohibit direct-to-consumer advertising of a drug
14 during the period beginning at the end of the 3-year
15 period described in paragraph (1)(A) if the Sec-
16 retary determines that the drug has significant ad-
17 verse health effects based on post-approval studies,
18 risk-benefit analyses, adverse event reports, the sci-
19 entific literature, any clinical or observational stud-
20 ies, or any other appropriate resource.

21 “(b) REGULATIONS.—Not later than 1 year after the
22 date of the enactment of this section, the Secretary shall
23 revise the regulations promulgated under this Act gov-
24 erning drug advertisements to the extent necessary to im-
25 plement this section.

1 “(c) RULE OF CONSTRUCTION.—This section shall
2 not be construed to diminish the authority of the Secretary
3 to prohibit or regulate direct-to-consumer advertising of
4 drugs under other provisions of law.”.

5 **SEC. 310. REPORTING ON JUSTIFICATION FOR DRUG PRICE**
6 **INCREASES.**

7 Title III of the Public Health Service Act (42 U.S.C.
8 241 et seq.) is amended by adding at the end the fol-
9 lowing:

10 **“PART W—DRUG PRICE REPORTING; DRUG**
11 **VALUE FUND**
12 **“SEC. 39900. REPORTING ON JUSTIFICATION FOR DRUG**
13 **PRICE INCREASES.**

14 “(a) DEFINITIONS.—In this section:

15 “(1) MANUFACTURER.—The term ‘manufac-
16 turer’ means the person—

17 “(A) that holds the application for a drug
18 approved under section 505 of the Federal
19 Food, Drug, and Cosmetic Act or the license
20 issued under section 351 of the Public Health
21 Service Act; or

22 “(B) who is responsible for setting the
23 price for the drug.

24 “(2) QUALIFYING DRUG.—The term ‘qualifying
25 drug’ means any drug that is approved under sub-

1 section (c) or (j) of section 505 of the Federal Food,
2 Drug, and Cosmetic Act or licensed under subsection
3 (a) or (k) of section 351 of this Act—

4 “(A) that has a wholesale acquisition cost
5 of \$100 or more per month supply or per a
6 course of treatment that lasts less than a
7 month and is—

8 “(i)(I) subject to section 503(b)(1) of
9 the Federal Food, Drug, and Cosmetic
10 Act; or

11 “(II) commonly administered by
12 hospitals (as determined by the Sec-
13 retary);

14 “(ii) not designated as a drug for a
15 rare disease or condition under section 526
16 of the Federal Food, Drug, and Cosmetic
17 Act; and

18 “(iii) not designated by the Secretary
19 as a vaccine; and

20 “(B) for which, during the previous cal-
21 endar year, at least 1 dollar of the total amount
22 of sales were for individuals enrolled under the
23 Medicare program under title XVIII of the So-
24 cial Security Act (42 U.S.C. 1395 et seq.) or
25 under a State Medicaid plan under title XIX of

1 such Act (42 U.S.C. 1396 et seq.) or under a
2 waiver of such plan.

3 “(3) WHOLESALE ACQUISITION COST.—The
4 term ‘wholesale acquisition cost’ has the meaning
5 given that term in section 1847A(c)(6)(B) of the So-
6 cial Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).

7 “(b) REPORT.—

8 “(1) REPORT REQUIRED.—The manufacturer of
9 a qualifying drug shall submit a report to the Sec-
10 retary for each price increase of a qualifying drug
11 that will result in an increase in the wholesale acqui-
12 sition cost of that drug that is equal to—

13 “(A) 10 percent or more over a 12-month
14 period; or

15 “(B) 25 percent or more over a 36-month
16 period.

17 “(2) REPORT DEADLINE.—Each report de-
18 scribed in paragraph (1) shall be submitted to the
19 Secretary not later than 30 days prior to the
20 planned effective date of such price increase.

21 “(c) CONTENTS.—A report under subsection (b)
22 shall, at a minimum, include—

23 “(1) with respect to the qualifying drug—

24 “(A) the percentage by which the manufac-
25 turer will raise the wholesale acquisition cost of

1 the drug on the planned effective date of such
2 price increase;

3 “(B) a justification for, and description of,
4 each manufacturer’s price increase that will
5 occur during the 12-month period described in
6 subsection (b)(1)(A) or the 36-month period de-
7 scribed in subsection (b)(1)(B), as applicable;

8 “(C) the identity of the initial developer of
9 the drug;

10 “(D) a description of the history of the
11 manufacturer’s price increases for the drug
12 since the approval of the application for the
13 drug under section 505 of the Federal Food,
14 Drug, and Cosmetic Act or the issuance of the
15 license for the drug under section 351, or since
16 the manufacturer acquired such approved appli-
17 cation or license;

18 “(E) the current list price of the drug;

19 “(F) the total expenditures of the manu-
20 facturer on—

21 “(i) materials and manufacturing for
22 such drug; and

23 “(ii) acquiring patents and licensing
24 for such drug;

1 “(G) the percentage of total expenditures
2 of the manufacturer on research and develop-
3 ment for such drug that was derived from Fed-
4 eral funds;

5 “(H) the total expenditures of the manu-
6 facturer on research and development for such
7 drug that is used for—

8 “(i) basic and preclinical research;

9 “(ii) clinical research;

10 “(iii) new drug development;

11 “(iv) pursuing new or expanded indi-
12 cations for such drug through supple-
13 mental applications under section 505 of
14 the Federal Food, Drug, and Cosmetic Act
15 or section 351 of the Public Health Service
16 Act; and

17 “(v) carrying out postmarket require-
18 ments related to such drug, including those
19 under section 505(o)(3) of the Federal
20 Food, Drug, and Cosmetic Act;

21 “(I) the total revenue and the net
22 profit generated from the qualifying
23 drug for each calendar year since the
24 approval of the application for the
25 drug under section 505 of the Federal

1 Food, Drug, and Cosmetic Act or the
2 issuance of the license for the drug
3 under section 351, or since the manu-
4 facturer acquired such approved appli-
5 cation or license; and

6 “(J) the total costs associated with mar-
7 keting and advertising for the qualifying drug;
8 “(2) with respect to the manufacturer—

9 “(A) the total revenue and the net profit
10 of the manufacturer for each of the 12- and 36-
11 month periods preceding the submission of the
12 report;

13 “(B) all stock-based performance metrics
14 used by the manufacturer to determine execu-
15 tive compensation for each of the 12- and 36-
16 month periods preceding the submission of the
17 report; and

18 “(C) any additional information the manu-
19 facturer chooses to provide related to drug pric-
20 ing decisions, such as total expenditures on—

21 “(i) drug research and development;
22 or

23 “(ii) clinical trials on drugs that failed
24 to receive approval by the Food and Drug
25 Administration; and

1 “(3) such other related information as the Sec-
2 retary considers appropriate.

3 “(d) CIVIL PENALTY.—Any manufacturer of a quali-
4 fying drug that fails to submit a report for the drug as
5 required by this section shall be subject to a civil penalty
6 of \$100,000 for each day on which the violation continues.

7 “(e) PUBLIC POSTING.—

8 “(1) IN GENERAL.—Subject to paragraph (3),
9 not later than 30 days after the submission of a re-
10 port under subsection (b), the Secretary shall post
11 the report on the public website of the Department
12 of Health and Human Services.

13 “(2) FORMAT.—In developing the format of
14 such report for public posting, the Secretary shall
15 consult stakeholders, including beneficiary groups,
16 and shall seek feedback on the content and format
17 from consumer advocates and readability experts to
18 ensure such public reports are user-friendly to the
19 public and are written in plain language that con-
20 sumers can readily understand.

21 “(3) TRADE SECRETS AND CONFIDENTIAL IN-
22 FORMATION.—In carrying out this section, the Sec-
23 retary shall enforce applicable law concerning the
24 protection of confidential commercial information
25 and trade secrets.

1 **“SEC. 39900–1. USE OF CIVIL PENALTY AMOUNTS.**

2 “The Secretary shall, without further appropriation,
3 collect civil penalties under section 39900 and use the
4 funds derived from such civil penalties, in addition to any
5 other amounts available to the Secretary, to carry out ac-
6 tivities described in this part and to improve consumer and
7 provider information about drug value and drug price
8 transparency.

9 **“SEC. 39900–2. ANNUAL REPORT TO CONGRESS.**

10 “(a) IN GENERAL.—Subject to subsection (b), the
11 Secretary shall submit to Congress, and post on the public
12 website of the Department of Health and Human Services
13 in a way that is easy to use and understand, an annual
14 report—

15 “(1) summarizing the information reported pur-
16 suant to section 39900; and

17 “(2) including copies of the reports and sup-
18 porting detailed economic analyses submitted pursu-
19 ant to such section.

20 “(b) TRADE SECRETS AND CONFIDENTIAL INFORMA-
21 TION.—In carrying out this section, the Secretary shall
22 enforce applicable law concerning the protection of con-
23 fidential commercial information and trade secrets.”.

1 **TITLE IV—OUTCOMES AND**
2 **REPORTING**

3 **SEC. 401. SENSE OF CONGRESS.**

4 It is the sense of Congress that Medicare for America
5 will have a significant impact on the health and well-being
6 of the United States population and the social deter-
7 minants of the health of beneficiaries of Medicare for
8 America.

9 **SEC. 402. EVALUATION OF BILL'S OUTCOME.**

10 (a) IN GENERAL.—To assess the impact of this Act
11 on the health of the population, not later than 2 years
12 after the date of the enactment of this Act, the Secretary
13 of Health and Human Services shall allow for analysis of
14 administrative records that have removed all personally
15 identifiable information from the Center for Health Care
16 to existing population surveys conducted by the Federal
17 Government and federally supported surveys.

18 (b) CDC AND NIH.—The Directors of the Centers
19 for Disease Control and Prevention and the National In-
20 stitutes of Health shall solicit a comprehensive, longitu-
21 dinal study to evaluate any differential individual impact
22 on coverage expansion based on—

- 23 (1) race and ethnicity;
24 (2) socioeconomic status; or
25 (3) health status.

1 (c) REPORT.—Ten years after the date of the enact-
2 ment of this Act and every ten years thereafter, the Sec-
3 retary shall submit a report to the House Committee on
4 Energy and Commerce and the Senate Committee on
5 Health, Education, Labor, and Pensions regarding the im-
6 pact of this Act on the health of the United States popu-
7 lation based on the results of subsection (b) contributions
8 from all other relevant agencies.