Comprehensive Health Care Reform Act of 2025

A BILL
To establish a comprehensive national health program providing universal coverage for all Americans, emphasizing preventive and value-based care, ensuring affordable medicines, integrating health services, and eliminating burdensome medical debt, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Title I – General Provisions

SEC. 101. SHORT TITLE. This Act may be cited as the **"American Health Security and Care Modernization Act of 2025."**

SEC. 102. FINDINGS AND PURPOSE.
(a) Findings.— Congress finds the following:
1. **Persisting Coverage Gaps and Need for Universality:** The United States remains the only major developed nation without universal health coverage, leaving roughly 7.7% of the population (about 26 million people) uninsured[1] and tens of millions more underinsured with high out-of-pocket costs. Approximately 85 million Americans are either uninsured or inadequately insured, despite the nation spending nearly $13,000 per person on health care – about twice the per-capita health spending of other wealthy countries[2]. This disconnect contributes to worse health outcomes; for example, U.S. life expectancy is about 4.5 years shorter than in Germany, and the U.S. has one of the highest infant mortality rates among high-income nations[3]. A new national program that replaces Medicare with a universal coverage system (under a new name to avoid stigma) would include all citizens regardless of income or age, eliminating fragmented coverage tiers and ensuring equitable access to care as a basic right.
2. **Preventable Chronic Disease Burden:** Chronic diseases such as heart disease, diabetes, and others account for approximately 90% of the nation's $4.9 trillion in annual health expenditures[4]. Yet experts estimate that about half of chronic conditions are preventable with effective public health measures and timely care[5]. The current health system too often treats illness after it arises rather than investing in prevention and wellness. Strengthening preventive care, early intervention, and value-based care models that reward health outcomes (not just volume of services) will reduce the burden of chronic disease, improve Americans' quality of life, and yield long-term savings.
3. **Rising Health Costs and Prescription Drug Prices:** The United States spends far more on prescription medications than other countries. On average, U.S. drug prices are **2.5 to 3 times** the prices paid in other high-income nations[6]. Moreover, many drugs have seen annual price hikes far above general inflation – in one period, about half of all drugs covered by Medicare had price increases exceeding the inflation rate[7]. These high costs

strain patients and federal programs. In 2022, Congress took a preliminary step by allowing Medicare to negotiate prices for a limited number of high-cost drugs (10 drugs in 2026, rising to 20 by 2029), but this authority is narrow in scope[8]. Empowering the federal government to negotiate prices for a broad range of drugs, capping patients' out-of-pocket drug expenses, and curbing monopolistic practices (such as "pay-for-delay" agreements that delay generics) can dramatically reduce drug costs. The Federal Trade Commission estimates that pay-for-delay deals alone cost Americans **$3.5 billion** annually in higher prices[9]. Robust price negotiations and competition will help align U.S. drug prices with international standards and make medications affordable for all.

4. **Fragmented Care and Need for Integration:** The U.S. healthcare delivery system is highly fragmented, with patients often navigating separate silos for primary care, specialty care, mental health, and social services. Fragmented care – where a patient sees multiple providers who fail to coordinate – leads to poor communication among providers, avoidable hospital and emergency department use, redundant tests, and higher medical costs[10]. Patients in fragmented systems report lower satisfaction, whereas those receiving more comprehensive, coordinated care (e.g. through a primary care provider who manages their conditions) have better experiences[11]. Aligning incentives across providers and integrating services can improve health outcomes and efficiency[12]. Integration of mental health care into primary care is especially critical, as untreated behavioral health needs exacerbate physical health conditions. A seamless health system that coordinates across medical, behavioral, and social domains will ensure patients receive "whole-person" care without gaps or duplication.

5. **Medical Debt Crisis:** Medical debt has become a widespread crisis in America. More than **100 million** people (around 41% of adults) are saddled with health-related debt[13]. In the last five years alone, over half of U.S. adults report incurring debt due to medical or dental bills, and one in five indebted individuals do not expect to ever pay it off[14]. Unpaid medical bills are a leading cause of personal bankruptcy: an estimated $88 billion in medical debt is currently in collections nationwide, and about **530,000** Americans are driven into bankruptcy each year in part due to medical expenses and time lost from work[15]. Aggressive debt collection practices – including lawsuits, wage garnishments, exorbitant interest, and credit report blackmarks – compound the harm to patients recovering from illness. Addressing the medical debt crisis by protecting patients from predatory collection, expanding financial assistance, and forgiving catastrophic health debts is necessary to restore financial security and ensure that illness or injury does not spiral into economic ruin for American families.

(b) Purpose.— The purpose of this Act is to comprehensively reform the United States health care system by establishing a new national health program that guarantees universal coverage and access to care for all Americans, while improving health outcomes and financial security. The Act's provisions aim to: (1) **achieve universal coverage** by replacing Medicare with a new inclusive program for all ages, thereby unifying and simplifying health insurance; (2) **promote preventive and value-based care** to reduce disease burden and reward quality over quantity; (3) **make medications affordable** through government negotiation of drug prices, caps on out-of-pocket costs, and

measures to end pharmaceutical price-gouging; (4) **integrate care delivery** across primary, specialty, mental health, and social services for a patient-centered, coordinated care experience; and (5) **end the plague of medical debt** by curbing aggressive collection practices, expanding financial aid for medical bills, and providing relief for individuals devastated by catastrophic health costs. Through these reforms, this Act strives to improve the nation's health outcomes, control costs, and ensure that no American faces bankruptcy or barriers to care due to medical needs.

SEC. 103. DEFINITIONS. Unless otherwise specified, in this Act:
1. **"Secretary"** means the Secretary of Health and Human Services.
2. **"National Health Program"** (hereafter in this Act, the **"NHP"** or **"the Program"**) means the universal public health coverage program established under Title II of this Act.
3. **"Medicare"** means the federal health insurance program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as in effect prior to enactment of this Act. **"Medicaid"** means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).
4. **"Eligible individual"** means a person who is entitled to receive benefits under the National Health Program as provided in section 201, generally encompassing all United States citizens and lawful permanent residents.
5. **"Preventive services"** means evidence-based items or services intended to prevent disease or detect health conditions early, including immunizations recommended by the Advisory Committee on Immunization Practices and preventive screenings or interventions with an "A" or "B" rating from the United States Preventive Services Task Force, as well as prenatal and pediatric care and other services as determined by the Secretary.
6. **"Value-based payment model"** means a payment system for health care services that links reimbursement to quality of care and patient health outcomes, rather than solely volume of services. This includes models such as accountable care organizations, bundled payment arrangements, patient-centered medical homes, and other alternative payment methodologies that incentivize high-quality, efficient care.

(End of Title I)

Title II – Establishment of the National Health Program (Universal Coverage)

SEC. 201. ESTABLISHMENT OF UNIVERSAL NATIONAL HEALTH PROGRAM.
(a) **In General.—** There is hereby established a federal program, to be known as the **"National Health Program" (NHP)**, administered by the Department of Health and Human Services, that will provide universal health insurance coverage and medically necessary health care benefits to all eligible individuals in the United States. The NHP shall replace the Medicare program and shall serve as the primary source of health coverage for U.S. citizens and lawful permanent residents, regardless of age, income, employment, or health status.

(b) **Eligibility and Enrollment.—** Every individual who is a citizen or lawful permanent resident of the United States is automatically eligible for and entitled to benefits under the National Health Program. The Secretary shall ensure a straightforward enrollment process for all eligible individuals. To facilitate universal participation, the following measures shall apply:

1. **Automatic Enrollment at Birth or Residency:** All infants born in the United States shall be automatically enrolled in the NHP at birth. All persons who later become U.S. citizens or lawful permanent residents shall be enrolled upon attaining such status.
2. **Continuous Coverage:** Once enrolled, individuals shall remain covered for life with no periodic re-enrollment required, so long as they maintain eligibility (which, for U.S. citizens, is lifelong, and for lawful permanent residents continues so long as such status is maintained). Coverage shall not lapse due to any change in employment, income, health condition, or state of residence.
3. **Enrollment Outreach:** The Secretary, in coordination with the Commissioner of Social Security and other relevant officials, shall conduct public outreach and education to inform individuals of their coverage and to facilitate smooth transitions for those currently insured under other programs. The Secretary may utilize Social Security Administration field offices, Health Insurance Marketplace infrastructure, and other federal or state agencies to assist in enrolling any individuals who are not yet captured by automatic procedures. No fees or premiums shall be required to enroll or maintain enrollment in the Program, except as provided under subsection (d) for certain income-based contributions.

(c) **Comprehensive Benefits.—** The health benefits under the NHP shall be comprehensive and cover all medically necessary care. At a minimum, covered benefits shall include: hospital care (inpatient and outpatient); surgical and medical services; primary and preventive care; specialist care; mental health and substance use disorder treatment; prescription drugs and medical devices; laboratory and diagnostic services; maternity and newborn care; pediatric care (including dental and vision services for children); emergency and trauma care; rehabilitative and habilitative services and devices; chronic disease management; physical, occupational, and speech therapy; durable medical equipment; home health care; and **long-term care services** (including skilled nursing facility care and home and community-based services) to the extent determined appropriate by the Secretary. The scope of benefits shall be no less than that available under the Medicare program as of the date of enactment, and shall also encompass the "essential health benefits" categories defined in section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)). Preventive services (as defined in Sec. 103) and vaccines shall be covered with no cost-sharing to the patient, in accordance with Title III of this Act. The Secretary, through rulemaking, may modify or expand the list of covered benefits to promote the health of beneficiaries, respond to advances in medical science, and meet emerging public health needs.

(d) **Affordability and Cost-Sharing Protections.—** The NHP shall protect all individuals from financial barriers to care. **No enrollment premiums** shall be charged to individuals for coverage under the Program (any necessary financing contributions from taxpayers or employers will be addressed separately in law and are not to be collected as insurance

premiums from individuals). For covered benefits, **cost-sharing** (such as deductibles, co-payments, or co-insurance) shall be minimal or zero, consistent with ensuring access and preventing medical debt. In particular:
- **Preventive Services:** All preventive services and vaccinations recommended by federal guidelines shall be provided **without any co-payment or deductible** to the patient.
- **Annual Out-of-Pocket Cap:** The Program shall include an annual limit on out-of-pocket spending for covered medical services and drugs. No individual shall be required to pay more than **$2,000 per year** in total cost-sharing for all covered benefits (and no family more than **$4,000 per year**), regardless of income. These caps shall be adjusted annually for inflation (using the Consumer Price Index for All Urban Consumers) and may be lowered by the Secretary if feasible. Once an individual or family reaches the out-of-pocket cap in a coverage year, the Program shall cover 100% of further covered expenses for that year.
- **Low-Income Protections:** Individuals and families with limited income shall have reduced or zero cost-sharing requirements. At a minimum, no cost-sharing shall apply to individuals or families with household income at or below 200% of the Federal Poverty Level (FPL), and the Secretary is authorized to establish a sliding scale of cost-sharing for incomes above 200% FPL, phasing out cost-sharing entirely for those who cannot afford it. Any cost-sharing that is imposed under the Program must be **nominal** and designed not to deter necessary care. The Secretary may waive or reduce cost-sharing for certain high-value services or for beneficiaries with chronic diseases to encourage adherence to treatment (for example, diabetes management supplies could be exempt from co-pays).

(e) **Freedom of Choice of Provider.—** Enrollees in the National Health Program shall have free choice of doctors, hospitals, and other providers or facilities participating in the Program. There shall be no **network restrictions** that limit a patient's choice of provider, and no balance billing beyond the approved Program rates (providers must accept the NHP reimbursement as payment in full for covered services, aside from any cost-sharing authorized by subsection (d)). The Secretary shall establish procedures to ensure adequate provider participation so that all regions have accessible primary care and specialist services.

(f) **Relation to Other Coverage; Prohibition on Duplicative Benefits.—** Beginning on the effective date of the NHP coverage (as specified in Title VII), the benefits provided under this Act shall supersede any equivalent benefits under other federal health care programs for eligible individuals, as well as eliminate the need for private comprehensive health insurance. Specifically, when the NHP is operative: (1) the Medicare program shall cease to enroll new beneficiaries (with all existing Medicare beneficiaries transitioned into the NHP for their health coverage, as detailed in section 205); (2) state Medicaid programs and the Children's Health Insurance Program (CHIP) shall continue to operate only for services or populations not covered by the NHP (such as certain long-term care services, if those remain outside the NHP's scope, or supplemental wrap-around services), with core medical benefits for Medicaid/CHIP enrollees to be provided through the NHP; and (3) it shall be unlawful for a private health insurance issuer to sell health insurance coverage that duplicates the benefits provided under the NHP. Private companies may, however,

offer insurance for benefits **not** covered by the NHP (for example, for elective cosmetic surgery or private hospital rooms) or provide supplemental coverage for any cost-sharing required by the Program. Nothing in this Act shall preempt an employer's ability to provide on-site clinics or supplemental health benefits that do not duplicate the core coverage of the NHP. The intent is that the National Health Program will become the single universal platform for basic health coverage in the United States, simplifying administration and ensuring everyone has the same foundational benefits.

SEC. 202. ADMINISTRATION OF THE PROGRAM AND FEDERAL-STATE COOPERATION.
(a) **Administration by CMS; Program Operations:** The Centers for Medicare & Medicaid Services (CMS) shall administer the National Health Program, acting through a dedicated office or center established for this purpose (which may be designated as the "National Health Program Administration"). The Administrator of CMS, under the direction of the Secretary, shall have primary responsibility for implementing the Program, including enrolling beneficiaries, establishing provider payment rates, processing claims, and ensuring quality and program integrity. The Secretary may develop new administrative infrastructures or adapt existing Medicare administrative contractors to carry out claims processing and provider payments under the NHP. Wherever practical, existing Medicare rules, data systems, and personnel shall be leveraged to expedite implementation, except as modified by this Act.

(b) **Federal and State Roles:** The NHP is federally administered and funded, superseding the patchwork of separate state-run insurance marketplaces or Medicaid expansions for the covered benefits. However, recognizing the value of local governance and experience, the Secretary shall work in partnership with state governments for certain functions. The Secretary may, by agreement, delegate to willing and capable states operational tasks such as enrollment assistance, local provider contracting, or oversight of quality and consumer protection, provided that all such state activities adhere to uniform national standards set by the Secretary. States may establish state health program offices to coordinate with CMS for the NHP implementation within the state. Any state that previously operated a state-based Marketplace under the Affordable Care Act or administered Medicaid managed care may apply to serve as an intermediary in administering NHP benefits, subject to federal approval and oversight. All core funding for NHP benefits will be federal; states will not be required to contribute funds for NHP-covered services, though maintenance of effort for certain existing health programs might be specified by the Secretary to ensure smooth transitions (for example, state contributions to Medicaid long-term care could continue if those services remain partially outside NHP coverage).

(c) **Provider Participation and Reimbursement:** Any individual or entity licensed to furnish health care services in a state (including physicians, hospitals, clinics, pharmacies, group practices, nurses and other practitioners, suppliers of medical equipment, laboratories, etc.) may participate in the NHP subject to agreeing to Program rules and rates. The Secretary shall establish a uniform national fee schedule or rate structure for reimbursing covered services, which may be adjusted for factors such as geographic cost

variations, provider type, or facility characteristics. Payment methods may include fee-for-service payments, bundled or global payments, capitation payments to organized health systems, salaries for institutional providers, or other methodologies consistent with quality and efficiency (with a strong emphasis on value-based models as addressed in Title III). The initial reimbursement rates shall be based on Medicare payment rates (Parts A, B, and D, as applicable) as a floor, and may be adjusted upward for services where Medicare rates are determined to be inadequate to ensure provider participation or to address access gaps. For services not traditionally covered under Medicare (such as pediatric or maternity care), the Secretary shall establish appropriate rates by reference to typical private insurance or Medicaid rates, with the goal of ensuring adequate access and fair compensation. Providers shall not charge NHP patients above the set rates (no balance billing), except for any allowed cost-sharing. The Secretary is authorized to negotiate prospective global budgets or alternative payment contracts with health care institutions (such as global budgets for hospitals or capitated budgets for integrated health systems) to promote cost stability and high-quality care, especially for large hospitals and academic medical centers.

(d) **Health Care Infrastructure and Workforce:** To ensure the success of the NHP, the Secretary shall identify needs in the health care workforce and infrastructure and is authorized to address those needs. This may include: incentives to train and recruit additional primary care practitioners, nurses, mental health professionals, and other providers in shortage areas; grants or capital improvements for expanding health care facilities in underserved regions; and programs to support the transition of insurance industry workers who may be displaced by administrative simplification (providing retraining or employment in the expanded public program administration or other health system roles). Funding for such workforce and infrastructure initiatives may be provided under the appropriations in Title VII or other sources as authorized by Congress.

(e) **Advisory Council:** The Secretary shall establish a National Health Program Advisory Council composed of representatives of patients, consumers, health care providers (across disciplines, including physicians, nurses, allied health professionals), hospitals, public health experts, labor unions, employers, and state health officials. The Advisory Council shall meet regularly and advise the Secretary and CMS Administrator on issues of Program implementation, benefit design, quality improvement, patient experience, and any problems identified in access to care. The Council will also review and provide input on proposed regulations affecting the NHP. This structure is intended to ensure transparency and stakeholder engagement as the Program evolves.

(f) **Preemption of Conflicting Laws:** The provisions of this Act and the regulations issued thereunder shall supersede any State law or regulation that conflicts with the operation of the National Health Program. After the effective date of the Program, no State may enforce any law requiring residents to purchase duplicative health insurance coverage for benefits provided under the NHP, and any such requirements in State law (including those mandating participation in state-run insurance marketplaces for basic coverage) are preempted. However, states may retain and enforce patient protection laws, provider

licensing standards, and insurance regulations that do not prevent application of this Act (for example, states may continue to regulate supplemental insurance, impose additional quality and reporting requirements on providers, or maintain malpractice and scope-of-practice laws). Any state laws that expand patient rights or benefits beyond the federal floor (and do not undermine the NHP) are not preempted.

SEC. 203. TRANSITION FROM MEDICARE AND OTHER PROGRAMS.

(a) **Medicare Beneficiaries:** Beginning on the full implementation date of the NHP (as specified in Title VII, and anticipated to be January 1, 2027 unless otherwise determined), individuals who were enrolled in Medicare (including Parts A, B, and D, and Medicare Advantage plans under Part C) shall become participants in the National Health Program and receive their benefits through the NHP. All Medicare-entitled individuals, including those under 65 with disabilities and those with end-stage renal disease, will enjoy the expanded benefits of the NHP with no loss of coverage. The transition shall be designed to be seamless: current Medicare beneficiaries will not have to file new enrollments; they will be automatically deemed enrolled in the NHP. On the transition date, the Medicare entitlement for hospital and supplementary medical insurance under Title XVIII of the Social Security Act is **deemed satisfied by NHP coverage**, and Medicare Parts A, B, and D (and any Part C plans) shall cease to furnish duplicative benefits. The Secretary shall ensure continuity of care during this transition – for example, any person in the midst of a course of treatment under Medicare will continue to see their providers without interruption, now covered by the NHP. Funds in the Medicare Trust Funds (HI and SMI) shall be directed into the National Health Program's financing mechanism as applicable, to be used for providing health care under the NHP (see Title VII on financing).

(b) **Medicaid and CHIP:** On the NHP implementation date, federal Medicaid matching payments for medical assistance shall be restructured as follows: For acute and primary health services that are covered under the NHP, eligible Medicaid enrollees (including low-income children and adults) will receive those services through the NHP, and such services will be federally financed through the NHP rather than traditional Medicaid. To avoid any loss of benefits, the Secretary shall identify any Medicaid-covered benefit or category (such as certain long-term services and supports, dental care for adults if not included, etc.) that may not be fully covered by the NHP as of the transition date. Those services shall continue to be provided by state Medicaid programs with federal support, until and unless the NHP benefit package is further expanded to include them. Federal Medicaid payments to states will be adjusted: funds that would have been used to pay for services now covered by the NHP will be retained for NHP use, whereas states will continue to receive federal funds for any remaining Medicaid responsibilities (for example, institutional long-term care, home- and community-based services if initially outside NHP, or supplemental support programs). The Secretary, in consultation with the National Association of Medicaid Directors, shall issue detailed guidance within 6 months of enactment on how state Medicaid/CHIP agencies will coordinate with the NHP. Generally, low-income individuals who previously relied on Medicaid will have the same or better coverage through the NHP, and states will be relieved of the need to finance a portion of their care, except for agreed maintenance of effort in certain areas. Children enrolled in the

Children's Health Insurance Program (CHIP) shall similarly transition to the NHP for their primary coverage. During a defined transition period (which may last through the first plan year of NHP operation), if any person eligible for NHP has not yet been fully enrolled or is in a waiting period, the state Medicaid/CHIP program is authorized to act as a payer of last resort to ensure no gap in coverage, with federal reimbursement.

(c) **TRICARE, VA, IHS:** This Act does not immediately alter the Department of Veterans Affairs health system or the Indian Health Service, which will continue to operate their own direct care programs for veterans and Native Americans, respectively. Eligible veterans may utilize the NHP for non-VA providers if they choose, and Native Americans may also access care through the NHP outside of IHS. The Secretary of Defense, Secretary of Veterans Affairs, and Secretary of HHS shall jointly develop plans for how the NHP will coordinate with TRICARE (for military families), the VA system, and IHS to ensure these populations have full access to care with no duplication of payments. Veterans and Native Americans can effectively have dual eligibility – they may continue to use VA or IHS services as they do now (with those systems billing the NHP for reimbursement if permissible for services provided, or receiving budgetary support as currently structured), or seek any NHP-participating provider. The goal is to augment, not replace, the specialized care these systems provide, unless and until a determination is made in the future about integrating those systems into the NHP fully with their consent.

(d) **Private Insurance Transition:** Individuals who have private health insurance on the NHP effective date (whether employer-sponsored or individual coverage) may retain that coverage during a transition period ending no later than the full implementation date of the NHP. By that date, all duplicative major medical coverage will be phased out or converted to supplemental coverage. Employers who offer group health plans are encouraged to maintain coverage for their workers until the NHP is active, to prevent coverage gaps. During the first year of NHP operation, employers who continue to offer a health plan must coordinate benefits with the NHP (the NHP will become primary payer for covered benefits, and any employer plan can provide supplemental benefits or cost-sharing wraparounds). After the first year, employer-based coverage that duplicates NHP benefits should cease, as NHP will cover all necessary services. The Secretary and the Secretary of Labor (for ERISA plans) shall jointly issue regulations to facilitate the orderly wind-down or conversion of private health insurance plans. Workers who have collective bargaining agreements that include health benefits and that extend beyond the NHP start date shall not lose any collectively bargained health benefits; such agreements may be renegotiated to adjust for the advent of NHP, with any savings potentially redirected to other benefits or wages as agreed by the parties.

(e) **Continuation of Coverage During Transition:** The Secretary is authorized to establish interim risk pools or reimbursement programs to providers to ensure that, during the transition period (from enactment until full NHP coverage is in force), no person goes without needed coverage. For example, if the NHP is scheduled to begin on January 1 of a certain year and an individual loses other insurance prior to that, the Secretary may utilize an expanded Medicare buy-in or a temporary public program to cover that individual in the

interim. The Department shall also enforce existing laws (such as COBRA continuation coverage or ACA marketplace subsidies) to bridge any gaps until NHP is available. Funding for any such temporary measures is authorized as needed, and may draw upon the Implementation Fund provided in Title VII.

(f) **Regulations on Transition:** Not later than 12 months after enactment, the Secretary (in consultation with the Secretary of Treasury, Secretary of Labor, and heads of other relevant agencies) shall promulgate interim final regulations outlining the detailed transition plan from existing programs to the NHP. These regulations shall address enrollment processes for current beneficiaries of Medicare, Medicaid, CHIP, etc.; notices to beneficiaries and providers; handling of claims run-out and debts of terminated insurance plans; and the disposition of any reserve funds or trust funds of the replaced programs (for example, remaining balances in Medicare's Trust Funds, which shall be transferred to help finance the NHP). The regulations will ensure that the transition maximizes continuity of care and minimizes administrative disruption. All such regulations shall be consistent with the principles stated in this section and the overall goal of seamless coverage for all.

SEC. 204. FINANCING OF THE NATIONAL HEALTH PROGRAM. (a) **Trust Fund Establishment:** There is established in the Treasury of the United States a trust fund to be known as the **Universal Health Trust Fund** (hereafter the "Trust Fund"), which shall be used to finance the National Health Program. The Trust Fund shall consist of amounts appropriated or credited to it by law, including (1) any amounts that were formerly allocated to the Medicare Trust Funds (Hospital Insurance and Supplementary Medical Insurance Trust Funds) which are hereby transferred into the Universal Health Trust Fund as of the NHP start date; (2) an amount equivalent to the federal expenditures that would have been made for Medicaid and CHIP medical services now covered by the NHP; (3) dedicated revenue sources enacted to fund the NHP (such as taxes or premiums, if any, designated by Congress to support this Act); and (4) any other appropriations or transfers made to the Trust Fund. Amounts in the Trust Fund are appropriated and shall remain available without fiscal year limitation to reimburse providers for covered health services, to pay for prescription drugs and medical products under the NHP, and to pay for program administration and related activities authorized by this Act.

(NOTE: The specific tax changes or revenue provisions to fund the NHP – such as adjustments to payroll taxes, income taxes, or the creation of new health care taxes – are assumed to be provided in separate legislation or in a revenue title not included here. For the purposes of this Act, the focus is on authorizing spending and establishing the program. It is assumed Congress will ensure adequate funding through appropriate tax law changes. The Act thus authorizes the use of the Trust Fund for all NHP obligations.)

(b) **Prohibition on Cost Sharing Revenues:** No fees, premiums, or cost-sharing collections from individuals (aside from nominal co-pays if any) shall finance the Program, except that any cost-sharing paid by individuals (like co-pays) may be treated as offsetting receipts to the Trust Fund. The primary funding shall come from broad-based federal revenues.

(c) **Payments to Providers; Budget Targets:** Each year, the Secretary shall establish an annual budget for the National Health Program, projecting expenditures for covered health services and administration. The budget shall be developed in consultation with the Advisory Council and relevant experts, using factors such as projected utilization, population health needs, and cost-saving measures from negotiated drug prices and value-based care (per Titles III and IV). The Secretary shall strive to keep the growth rate of per-capita health spending under the NHP in line with general economic growth (GDP growth) or medical inflation if lower, while ensuring access and quality. In the event that aggregate spending in a fiscal year is projected to exceed the available funds in the Trust Fund, the Secretary must notify Congress with recommendations for securing additional funds or cost-control measures. However, **no automatic reductions in benefits or eligibility** shall be enacted due to budget considerations; funding shortfalls must be addressed by Congress through additional appropriations or revenue increases. All savings achieved through efficiency measures (such as reduced drug prices or administrative simplification) shall remain in the Trust Fund to further improve and expand health services, **not** diverted elsewhere. Congressional oversight of the Trust Fund will be provided via annual reports submitted by the Secretary on the financial status of the NHP, including detailed accounting of expenditures and sources of revenue.

(d) **Maintenance of Effort by States (MOE):** States are required to maintain their current level of effort in health care spending for certain categories during the transition, as determined by the Secretary, to prevent sudden reductions in public health or long-term care funding. Specifically, if states currently fund programs (like state-funded Medicaid benefits or public health programs), they must continue to contribute an equivalent amount for a period of years (to be set by the Secretary, e.g., a 3-year MOE) into either their continued responsibilities (like long-term care) or into the NHP indirectly (perhaps via a maintenance-of-effort payment to the Trust Fund) until the federal system fully absorbs those costs. The Secretary may waive the MOE requirement for a state facing severe fiscal hardship or if the NHP's financing mechanism has fully supplanted the need for state contributions.

(e) **Anti-Fraud and Abuse Measures:** The Secretary and the Inspector General of HHS shall implement robust program integrity measures to protect the Trust Fund. This includes applying and strengthening, as appropriate, the antifraud provisions of the Social Security Act (such as those in Medicare and Medicaid) to the NHP. False claims, kickbacks, or any form of fraud or abuse in the NHP shall carry penalties at least as stringent as those under current Medicare/Medicaid law (including fines, exclusion from program, and potential criminal liability pursuant to 18 U.S.C. §§287, 1347 and other applicable laws). The Act's broad expansion of coverage is predicated on reducing waste; thus detection and prevention of improper billing is paramount. The Secretary shall also invest in modern claims auditing technology and data analytics to identify anomalies, and shall encourage a culture of compliance among providers through education and clear guidelines.

(f) **No Cost-Shifting to Households:** It is the intent of Congress that overall national health expenditures be controlled and that any financing of the NHP be broadly shared based on ability to pay (e.g., through progressive taxation), rather than at point of service. Nothing in this Act shall be construed to permit the Secretary or any other entity to impose new direct charges on individual patients for the purpose of raising general revenue. Beyond the limited cost-sharing allowed in Sec. 201(d), the Program's financing must come from systemic sources, not individual illness or injury.

(End of Title II)

Title III – Preventive Care and Value-Based Health Care Reforms

SEC. 301. COVERAGE OF PREVENTIVE SERVICES AND HEALTH PROMOTION.
(a) **No-Cost Preventive Services:** The National Health Program shall prioritize prevention and wellness. All evidence-based preventive services and screenings shall be covered by the Program without any patient cost-sharing (no co-payment, deductible, or coinsurance). This includes, at a minimum: immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) for routine use; preventive care and screenings with a rating of "A" or "B" from the U.S. Preventive Services Task Force (such as cancer screenings, blood pressure, diabetes, and cholesterol tests, etc.); pediatric preventive services per Bright Futures guidelines; contraceptive services and counseling approved by the Food and Drug Administration; and prenatal and postnatal care. The Secretary shall regularly update the list of covered preventive services in line with the latest medical guidelines, and such updates shall take effect for coverage no later than 1 year after a new recommendation is issued. Providers shall be reimbursed for these preventive services at a fair rate, and they shall actively inform patients of available free preventive benefits.

(b) **Investment in Public Health and Community Prevention:** In addition to individual clinical preventive services, the Secretary shall allocate resources towards community-based prevention programs to address public health challenges such as obesity, tobacco use, and chronic disease management. The Act authorizes the expansion of the **Prevention and Public Health Fund** (as established by section 4002 of the Patient Protection and Affordable Care Act) with an additional mandatory appropriation of funds (as provided in Title VII or otherwise appropriated) to support prevention initiatives. These funds shall be used for grants to states, local health departments, tribes, and non-profit organizations to implement evidence-based interventions that promote wellness – for example, programs for smoking cessation, nutritional counseling, diabetes prevention programs, fall prevention for seniors, and anti-obesity campaigns in schools and workplaces. Priority shall be given to programs that address health disparities and the social determinants of health (such as projects ensuring access to healthy foods, safe spaces for physical activity, and culturally tailored health education in underserved communities). The Secretary, through the CDC and other agencies, will set measurable goals (like reducing the incidence of type-2 diabetes or hypertension rates) and annually report to Congress on progress in prevention outcomes as a result of these investments.

(c) **Chronic Disease Management and Wellness Incentives:** The National Health Program shall include coverage for chronic disease management programs and authorize new approaches to keep people healthy. This includes coverage of medical nutrition therapy, diabetes self-management training, health coaching, and other evidence-based educational or support services for individuals with chronic conditions (such as asthma, diabetes, hypertension, heart disease, mental illness, etc.). The Secretary is directed to develop **wellness incentive pilot programs** within the NHP whereby enrollees who participate in approved wellness activities (for instance, completing a diabetes prevention class or a hypertension management program) could receive benefits such as reduced cost-sharing or reward vouchers (as long as such incentives are equitable and do not penalize those with serious illness). Any such program must comply with non-discrimination rules – the incentives should reward positive actions without reducing benefits for those unable to participate. The Secretary shall evaluate these pilot programs for effectiveness in improving health outcomes and reducing costs (for example, tracking reductions in HbA1c levels among diabetic participants or decreased hospitalizations for heart failure after diet/exercise counseling programs). If proven successful, the Secretary may expand these programs nationwide.

(d) **School and Workplace Health Initiatives:** To further embed prevention in daily life, the Act encourages intersectoral collaboration. The Secretary of HHS, in collaboration with the Secretary of Education and Secretary of Labor, shall support initiatives to make schools and workplaces healthier environments. Subject to the availability of funds, grants may be provided for: evidence-based school health programs (such as school nurses, health education curricula, mental health services in schools, healthy school meals, physical education enhancements) and workplace wellness programs (such as stress management, workplace exercise facilities, vaccination clinics at large employers, or healthy workplace certification programs). While participation by employers and schools is voluntary, the Secretary shall disseminate best practices and consider incentives (like a temporary tax credit or public recognition) for employers who adopt robust wellness programs that meet standards to be set by HHS and Labor. The goal is to reduce illness and injury at the population level, beyond clinical settings.

(e) **Research and Tracking:** The Secretary, acting through agencies such as the CDC and National Institutes of Health, shall intensify research into preventive care and population health. This includes comparative effectiveness research on preventive interventions and collecting data on health outcomes to see where prevention is most effective. The National Health Program's data infrastructure shall be utilized to monitor utilization of preventive services and resulting health metrics (for example, tracking cancer screening rates and subsequent cancer incidence or stage at diagnosis across the population). Any data collected will protect individual privacy but can be used to guide policy (for instance, identifying geographic or demographic gaps in preventive care uptake and addressing them).

SEC. 302. TRANSITION TO VALUE-BASED CARE AND PAYMENT.

(a) **Expansion of Alternative Payment Models (APMs):** The Secretary of Health and

Human Services shall accelerate the transition from fee-for-service payment to value-based payment models within the National Health Program. Building on the authorities of the Center for Medicare & Medicaid Innovation (CMMI) (section 1115A of the Social Security Act) and other initiatives, the Secretary is mandated (not merely authorized) to implement or expand successful payment and service delivery models that improve quality and reduce costs. By January 1, 2027 (the anticipated first year of NHP full operation), the Secretary shall ensure that a significant proportion of payments to providers under the NHP (target of at least 50%) are through **alternative payment models** that tie reimbursement to performance on quality and efficiency metrics. These models may include, but are not limited to: Accountable Care Organizations (ACOs) where groups of providers assume responsibility for the health outcomes and total cost of care of a population of NHP beneficiaries (with shared savings or risk arrangements); bundled episode payments for major procedures or conditions (e.g., a single payment for all services associated with a cardiac bypass surgery or joint replacement, incentivizing coordination and avoiding complications); primary care medical homes receiving per-member monthly care coordination fees and bonuses for achieving better health outcomes; and global budgets or capitated payments for integrated delivery systems or hospitals, adjusted for patient volume and quality.

(b) **Quality Measurement and Reporting:** To support value-based purchasing, the Secretary shall develop a core set of standardized **quality measures** that will be used to evaluate provider performance across the NHP. These measures shall include outcomes measures (such as hospital readmission rates, infection rates, control of chronic disease indicators like blood pressure or blood sugar levels in populations, patient functional status improvements), patient safety metrics, patient experience/satisfaction surveys, and measures addressing health equity (like reduction in disparities among subpopulations). Providers participating in APMs will be required to report relevant data on these measures. The Secretary shall publicly report aggregated performance data by provider or health system in a manner accessible to consumers (for example, creating a public “scorecard” for ACOs or hospitals). However, in doing so the Secretary must ensure data accuracy and risk adjustment so that providers are compared fairly, accounting for patient complexity.

(c) **Payment Incentives for Quality and Efficiency:** Under the NHP fee schedule or payment system, the Secretary shall incorporate payment incentives such that high-performing providers (as measured by the quality metrics in subsection (b)) are rewarded and under-performing providers are encouraged to improve. For example, the Secretary can implement value-based adjustments to hospital payments (like the current Medicare Hospital Value-Based Purchasing and Readmissions Reduction Programs) now applied to all NHP-covered hospitals: hospitals with better outcomes and patient satisfaction may receive bonus payments, whereas those with excessive avoidable readmissions or hospital-acquired conditions may see reductions in reimbursement. Similarly, physicians and other practitioners could receive incentive payments for high quality care (e.g., meeting targets for preventive care delivery, chronic disease control, or appropriate use of diagnostics). Any such adjustments should be budget-neutral or savings-producing (meaning bonuses are offset by penalties or overall cost reductions), and must be

designed to avoid penalizing providers who treat sicker or more complex patients (adequate risk adjustment and peer grouping is required). Special attention will be given to rural and safety-net providers to ensure these incentives do not inadvertently disadvantage them; the Secretary may provide technical assistance and possible exemptions or adjustments for small or sole-community providers during initial phases.

(d) **Health Information Technology and Interoperability:** Achieving value-based, coordinated care requires robust health information exchange. The Secretary shall promulgate standards (building on the 21st Century Cures Act and existing HHS rules) to ensure **interoperability** of electronic health records (EHRs) and other health IT systems among all providers participating in the National Health Program. All providers receiving reimbursement under the NHP must make a reasonable effort to utilize certified EHR technology that can securely exchange clinical data with other providers (subject to patient privacy rights under HIPAA and other laws). The Office of the National Coordinator for Health IT (ONC) shall enforce information-blocking prohibitions to ensure that providers or IT vendors do not impede appropriate sharing of patient information. The goal is that any clinician caring for an NHP patient can access that patient's relevant medical history, medication list, and test results from other providers as needed for treatment, thereby reducing duplication and improving care transitions. Federal incentive programs (like expanded HITECH Act-style grants) may be used to assist small or under-resourced providers in adopting and optimizing EHRs. By two years after NHP implementation, the Secretary (through ONC and CMS) shall certify that a nationwide health information exchange network is operational for NHP providers, enabling, for example, a treating physician in one state to retrieve a patient's records (with consent) from another state's hospital if the patient recently moved or traveled.

(e) **Addressing Social Determinants and Care Coordination:** Recognizing that improved value often comes from addressing non-medical factors that affect health, the Secretary is authorized to allow **flexible benefits or payments** in alternative models to address social determinants of health. For instance, an ACO or health plan within the NHP might use a portion of savings to fund a nutrition program, transportation for medical appointments, housing referrals for homeless patients, or other interventions that, while not traditional medical services, have been shown to improve health outcomes and reduce medical utilization. The Secretary shall issue guidance on how NHP funds or shared savings can be used for such services. Additionally, the Program shall reimburse for **care coordination services**: e.g., paying for case managers, community health workers, or care coordinators especially for patients with complex, multi-faceted needs. These services might include medication management, patient outreach after hospital discharges, coordination of referrals, and linking patients with community resources. By explicitly covering and valuing these coordination activities, the NHP aims to prevent patients from "falling through the cracks" and to avert costly complications.

(f) **Evaluation and Continuous Improvement:** The Secretary, through CMMI or other appropriate offices, shall rigorously evaluate the outcomes of value-based initiatives implemented under this section. This includes monitoring total expenditures, patient

outcomes, patient and provider satisfaction, and any unintended consequences (for example, stinting on care or risk selection). If an alternative payment model is not achieving the desired results (quality improvement and cost control), the Secretary may modify or terminate that model. Conversely, models that demonstrate success should be scaled up and made permanent parts of the NHP payment system. Within three years of NHP implementation, the Secretary shall submit a report to Congress detailing the status of the shift to value-based care, including statistics on how many providers are participating in APMs, how quality metrics have changed, and the impact on spending trends. The report should also include recommendations for any additional legislative authority needed to further the goals of high-value care. Congress's intent is that the National Health Program not only expands coverage, but also transforms care delivery to be **patient-centered, focused on outcomes, and economically sustainable** for future generations.

(End of Title III)

Title IV – Affordable Medicines and Pharmaceutical Reform

SEC. 401. FEDERAL NEGOTIATION OF DRUG PRICES.
(a) **Authority to Negotiate Prices:** Notwithstanding any other provision of law, the Secretary of Health and Human Services **shall have broad authority to negotiate** with pharmaceutical manufacturers the prices (and other appropriate payment terms) to be paid for prescription drugs, biological products, and insulin covered under the National Health Program. This authority replaces any prior prohibition on interference in drug price negotiations (such as that formerly found in section 1860D-11(i) of the Social Security Act for Medicare Part D) – those prohibitions are hereby repealed. The Secretary shall use the bargaining power of the federal program, which covers a vast number of Americans, to obtain drug prices that are reasonable and aligned with therapeutic value. Negotiation shall apply to all classes of drugs covered by the Program, including drugs provided in outpatient settings (which would parallel Medicare Part D/former ACA marketplace coverage) and drugs administered by physicians or in hospitals (analogous to Medicare Part B drugs), as well as vaccines and insulins.

(b) **Negotiation Process:** The Secretary shall establish a **Drug Price Negotiation Program** within HHS to carry out these negotiations. Each year, the Secretary shall identify a list of drugs for focused negotiation – this list should include, at minimum, (1) brand-name or biologic drugs that lack significant competition (no generic or biosimilar available) and have particularly high spending or prices, and (2) any drugs that the Secretary determines have had unjustified price increases or launch prices that threaten affordability. The number of drugs negotiated each year shall be sufficient to meaningfully reduce costs – the Secretary is expected to negotiate the prices of *dozens* of high-cost medications annually (not merely 10 or 20), scaling up to encompass a wide range of therapies. The negotiation shall consider factors including the drug's clinical effectiveness and value (possibly informed by comparative effectiveness research), R&D costs and federal investments, production and distribution costs, the prices charged in other countries for

the same drug (international reference prices), and the need for fostering innovation. The Secretary may employ value assessment techniques (like quality-adjusted life years or other outcome measures) in a careful, transparent manner to gauge a fair price, but shall also engage input from physicians, patient groups, and other stakeholders. Manufacturers of selected drugs will be required to enter into good-faith negotiations with the Secretary regarding the price to the Program.

(c) **Fallback if Negotiations Fail:** In the event that a manufacturer refuses to negotiate or the negotiations do not result in an agreed-upon maximum fair price by a reasonable deadline, the Secretary shall use other tools to ensure affordability. These tools include, but are not limited to: (1) **Reference Pricing:** unilaterally setting a reimbursement price for the drug in the NHP based on an average of prices in a group of reference countries (such as the OECD nations or a subset with comparable economies)[16]; (2) **Inflation Penalties:** imposing a rebate or civil monetary penalty on manufacturers that raise drug prices faster than inflation (to discourage price gouging year over year, extending the inflation-rebate provisions of the Inflation Reduction Act to all drugs in the Program); and (3) **Public Interest Licensing:** authorizing the use of patented medicines by generic manufacturers (domestically or via imports) despite existing patents or exclusivities – effectively a compulsory license – when necessary to guarantee access. Specifically, if a manufacturer will not agree to a reasonable price, the Secretary may invoke 28 U.S.C. §1498 or other applicable authority to allow the government or contracted entities to produce or procure a lower-cost generic or biosimilar version for use by Program beneficiaries, providing the original manufacturer reasonable compensation as determined by law. Use of this mechanism should be reserved for cases of egregious pricing or essential drugs where negotiation is at impasse, and the Secretary should promulgate regulations outlining the standards and process for such action.

(d) **Applicability to Other Federal Programs:** The prices negotiated by the Secretary for the NHP shall, by default, also be made available to other federal health programs and beneficiaries to promote uniformity and avoid price discrimination. This means that the Department of Veterans Affairs, Department of Defense (TRICARE), the Indian Health Service, and any other federal entities providing medications may have the option to purchase drugs at the prices (or better) achieved by the NHP negotiation, unless those agencies opt out due to having secured an even lower price through their own statutory authority. Similarly, manufacturers must offer the negotiated price to any provider dispensing drugs to NHP patients (including pharmacies, hospitals, etc., which will be reimbursed by NHP at that price). The Secretary shall coordinate with the VA and others to ensure that this expanded negotiation complements rather than conflicts with existing federal pricing (such as the VA Federal Supply Schedule or 340B pricing). Manufacturers are prohibited from engaging in tactics to circumvent the negotiated prices (for instance, by rebating selectively to private purchasers but not the government, or by restricting supply). The Secretary may issue regulations to prevent any such evasion and ensure the negotiated price truly becomes the effective price in the U.S. market for the Program's volume.

(e) **Transparency Requirements:** To inform negotiations and public accountability, manufacturers of drugs selected for negotiation shall, upon the Secretary's request, submit data on actual production costs, R&D expenditures (including public subsidies or scientific contributions), marketing and advertising expenses, and prices or revenue in domestic and international markets. The Secretary will keep truly proprietary data confidential as needed, but general findings (like if a drug's price is vastly above its manufacturing cost or global average price) should be disclosed to justify the government's negotiating stance. An **independent advisory committee** on pharmaceutical pricing, composed of clinicians, pharmacoeconomists, patient advocates, and industry representatives, may be established to provide non-binding guidance or recommendations to the Secretary on appropriate price ranges for negotiations, adding credibility and a public interest perspective to the process.

(f) **No Effect on Drug Coverage Decisions:** Nothing in this section shall be construed to mean that the NHP will not cover a drug if negotiations fail or if a manufacturer disagrees with the price. The Program intends to cover medically necessary drugs; however, if a manufacturer declines to sell to the Program at a reasonable price, the Secretary will use the enforcement tools in subsection (c) to ensure supply (through generics or importation). The Secretary does have discretion to establish a formulary or preferred drug list within the NHP (as discussed in Sec. 402) to encourage use of cost-effective therapies, but patient access to needed medications should be preserved.

(g) **Annual Reporting:** The Secretary shall report annually to Congress on the outcomes of drug price negotiations. The report shall include the list of drugs for which prices were negotiated that year, the agreed upon price reductions or terms (expressed in percentage off list price or other suitable metric, while respecting any confidentiality required), the estimated savings to the Program and to patients, and the impact on beneficiary access (e.g., no reported drug shortages or access problems as a result). The report should also summarize instances where fallback authorities were invoked (such as any compulsory license issued or reference price imposed) and the outcomes thereof. Additionally, the report will include the trend in overall pharmaceutical expenditures under the NHP and progress toward aligning U.S. drug prices with international norms[16].

SEC. 402. PRESCRIPTION DRUG AFFORDABILITY: OUT-OF-POCKET CAPS AND FORMULARY DESIGN.

(a) **Annual Out-of-Pocket Cap for Prescription Medications:** In order to protect individuals from catastrophic drug costs, the NHP's cost-sharing limitations (as described in Title II, Sec. 201(d)) shall specifically include an **annual prescription drug out-of-pocket maximum**. No enrolled individual shall be required to pay more than **$2,000 per year** in out-of-pocket costs for covered prescription drugs (inclusive of any co-pays or co-insurance for medications), and no family more than **$4,000 per year**, regardless of the number or cost of medications needed. These amounts are inclusive within the overall medical out-of-pocket cap set by the Program (not in addition to it). In other words, once a person has paid $2,000 toward drugs (or toward all health services combined, whichever comes first) in a year, the NHP will cover 100% of further prescription drug costs for that

year. This cap shall be adjusted annually for inflation in the same manner as the general cap. If a higher level of protection is already provided (for example, zero cost-sharing for low-income individuals or specific chronic disease drugs as arranged under Sec. 201(d)), those protections remain. This subsection ensures that no patient must forgo life-sustaining medications or incur crushing debt due to pharmacy bills.

(b) **Monthly Caps for Certain Drugs (e.g., Insulin):** In addition to the annual cap, certain essential medications that patients must take continuously (and which have been subject to particular price volatility) shall have regulated monthly co-pay limits. **Insulin products** are one such category of critical medicine. Notwithstanding any other provision, for any covered insulin product, an enrollee shall not be charged more than **$35 for a 30-day supply** of insulin, even if they have not yet met any deductible or out-of-pocket cap[6]. This $35 insulin cap shall apply for each month's supply and can be lower if the Secretary sets or the negotiated price yields a lower standard co-pay. The Secretary may, by rule, designate other classes of drugs to have a fixed nominal co-pay ceiling (for example, perhaps certain asthma inhalers or epinephrine auto-injectors) where urgent access is needed and price shocks have been common. These specific caps do not prevent an individual from reaching the overall $2,000 cap sooner; they simply ensure affordability per prescription fill.

(c) **Formulary and Tiered Co-Payments:** The Secretary is authorized to develop a **national formulary** for the NHP to promote the use of cost-effective and clinically appropriate medications. The formulary process shall involve clinical experts and consider comparative effectiveness and safety. If a formulary is used, it must include at least one drug in each therapeutic class (as defined by regulations) and provide a fair appeals process for coverage of non-formulary drugs when medically necessary. The Secretary may structure the cost-sharing for drugs in **tiers** to encourage generic and biosimilar use and the selection of high-value drugs. For instance, generic drugs and biosimilars could be set at very low or $0 co-pay (especially for chronic conditions), while brand-name drugs with generic equivalents might have higher co-pays (subject to the out-of-pocket caps). However, given the overarching intent to reduce patient costs, any tiered co-pays will be moderate and designed only for value steering, not cost-shifting. If drug tiers are established, differences in co-pays must reflect genuine cost or value differences and not simply penalize patients with certain conditions. The formulary design shall comply with mental health parity (no more restrictive access to psychotropic medications compared to other meds) and shall not discriminate on the basis of disease or disability.

(d) **Promotion of Generics and Biosimilars:** The Secretary shall implement policies to rapidly incorporate **generic drugs and biosimilar biologics** into the NHP formulary and usage once they become available, as they typically offer lower prices. This includes expediting any review needed to add a newly approved generic/biosimilar to covered status, educating providers and patients about the safety and efficacy of FDA-approved generics and biosimilars, and potentially preferentially tiering them with zero or minimal co-pays to incentivize their use. Furthermore, the Secretary will use the negotiation authority and other tools to prevent anti-competitive practices that delay generic or

biosimilar entry (see Sec. 403). Contracts with brand manufacturers in negotiation can include provisions that, if a generic enters the market, the NHP reserves the right to revisit the agreed price or to delist the brand in favor of the generic unless the brand significantly lowers its price. The aim is to achieve substantial savings by transitioning to lower-cost alternatives without compromising care quality.

(e) **Pharmacy Benefit Administration:** The Secretary may either administer the prescription drug benefit directly through CMS or use competitively bid pharmacy benefit managers (PBMs) or carriers in a manner similar to Part D plans, but under stricter federal oversight. If external PBMs or administrators are used, they shall act purely as agents of the government and **fiduciaries** for the Program, not for profit maximization. They must pass through all discounts or rebates to the Program or pharmacies, cannot exclude drugs except as consistent with the national formulary, and their compensation could be a fixed administrative fee rather than a percentage of drug costs (to remove incentives for high costs). The Secretary shall ensure that pharmacy networks are broad and accessible – all willing pharmacies can participate in the NHP under standard terms so that beneficiaries have choice of where to fill prescriptions (including independent community pharmacies). Mail-order options can be offered for convenience (particularly for maintenance medications), but patients must retain the option to use local pharmacies. Any PBM contracts will be transparent, with disclosure of rebate arrangements and no spread pricing (the practice where PBMs charge the payer more than they reimburse the pharmacy). If the Secretary finds that using private intermediaries is not yielding optimal results, HHS may centralize the drug benefit administration within Medicare/NHP operations to maximize efficiency and transparency.

(f) **Medication Therapy Management (MTM):** The Program shall include coverage for pharmacist-provided medication therapy management for patients with complex medication regimens (for example, those on multiple chronic medications or with multiple chronic diseases). Pharmacists and other qualified providers shall be reimbursed for MTM services such as comprehensive medication reviews, patient adherence counseling, and resolving medication-related problems. The Secretary shall integrate MTM into the standard of care especially for high-risk patients, as studies have shown it improves outcomes and can reduce adverse drug events and costs. MTM services may be targeted to patients identified by the Program's data as likely to benefit (e.g., taking 5 or more drugs, or with a history of medication issues). This is in line with the emphasis on value – ensuring medications are used effectively and safely, not just paying for pills dispensed.

SEC. 403. REDUCING MONOPOLISTIC DRUG PRACTICES AND ENHANCING COMPETITION.

(a) **Ban on Pay-for-Delay Agreements:** It is unlawful for any drug manufacturer to directly or indirectly compensate another manufacturer (typically a generic company) to delay the research, development, manufacturing, or marketing of a competing generic or biosimilar drug. Such agreements, commonly known as "pay-for-delay" settlements (or "reverse payment" agreements), are declared to be contrary to public policy and an unfair and anticompetitive practice. If a brand-name manufacturer and a generic (or biosimilar)

applicant enter into a patent litigation settlement or other agreement, they must report the terms to the Federal Trade Commission (FTC) and the Secretary of HHS. The FTC shall have authority to review and, if necessary, challenge any such agreement. Any payment or thing of value from a brand to a generic company, coupled with delayed entry of the generic beyond a date it otherwise might have entered, shall create a presumption that the agreement is anticompetitive and unlawful. The parties may rebut this presumption only with clear and convincing evidence that the value transfer was for something other than delay (such as compensation for unrelated services) and is reasonable in amount. Violators of this subsection shall be subject to substantial civil penalties – at minimum, a fine up to three times the value received by the generic firm in the agreement or three times the brand's estimated gain from delayed competition, whichever is greater[17]. The FTC is empowered to enforce this provision and may seek additional remedies including injunctions to undo the agreement or allow immediate generic entry. This ban applies to agreements regarding any drug under the jurisdiction of the FDA (both small-molecule and biologics).

(b) **Addressing Evergreening and Patent Abuse:** The Secretary of HHS, in coordination with the United States Patent and Trademark Office (USPTO) and the FTC, shall develop regulations or propose legislative changes to curb **evergreening** – the practice of obtaining additional patents or exclusivities on minor modifications of existing drugs to extend monopoly protection without significant therapeutic improvement. Key measures shall include:

1. **Patent Transparency and Review:** Requiring companies to disclose to the FDA and USPTO any new patents on an already-approved drug and demonstrate that such patents cover genuinely new innovations (for example, a significant new use or improved formulation that enhances efficacy or safety) rather than trivial changes. The FDA shall not list in its "Orange Book" patents that do not meet statutory criteria of patentability and relevance to the drug's approved uses. The USPTO is encouraged to more rigorously examine pharmaceutical patent applications, especially continuation or secondary applications, to prevent unjustified extensions.
2. **Limiting FDA Market Exclusivity Extensions:** For drugs that receive additional FDA-granted exclusivities (such as new clinical investigation exclusivity for a new indication, or orphan drug exclusivity), the Secretary shall ensure these do not inappropriately delay generic competition beyond what patent law would allow. If a brand drug is nearing end of patent protection, the FDA shall, where scientifically feasible, allow generics/biosimilars to carve out the protected new indication and enter the market for the original uses. Orphan drug exclusivity shall be narrowly applied to the specific rare condition, not to block competition for common uses of the same drug.
3. **Combination Products and Minor Reformulations:** If a manufacturer introduces a new version of a drug (like an extended-release formulation or a single-pill combination of two older drugs) and seeks to shift patients to it while generic competition for the original is imminent, the Secretary can take steps to encourage competition. For instance, FDA could prioritize review of generics to the new combo or formulation, or decline to grant any "bonus" exclusivity if it appears primarily intended to thwart generics. In cases where a

manufacturer withdraws an older formulation from the market in order to force use of a newly patented formulation, the FDA may allow generic approval referencing the old formulation (using historical data) despite its withdrawal, if the withdrawal was for reasons other than safety or effectiveness.

Additionally, the Act makes it an unfair method of competition under the FTC Act for a manufacturer to make product changes (such as modifying a drug's dosage form or delivery mechanism) primarily to impede generic entry (sometimes called "product hopping"). The FTC can challenge such conduct, and courts can order relief including compulsory licensing of the relevant patents to generic firms or mandating the brand to continue supplying the original product to generic manufacturers for reference.

(c) **Reducing Biologic Exclusivity and Expediting Biosimilars:** Section 351(k)(7)(A) of the Public Health Service Act (42 U.S.C. 262(k)(7)(A)), which establishes exclusivity for reference biologic products, is hereby **amended** by striking "12 years" and inserting "**7 years**". This change means that new biologic drugs will have a shorter guaranteed monopoly period before biosimilar competition can be approved by FDA, accelerating patient access to lower-cost biosimilars while still providing a period for innovators to recoup investments. This amendment shall apply to biologics first licensed after enactment of this Act (and, for biologics currently within their exclusivity period, any remaining exclusivity shall be truncated to 7 years total from licensure, unless they are already beyond 7 years at enactment, in which case they lose exclusivity immediately). The FDA is directed to streamline its review process for biosimilars, including providing clearer guidance on demonstrating interchangeability, to promote robust biosimilar uptake. The Secretary shall also consider policies like allowing temporary naming conventions that better signal substitution (for example, biosimilars could share a core name with the reference product to encourage pharmacist substitution where appropriate, consistent with state laws). The goal is to make biosimilar competition as effective in bringing down prices for biologic medicines as generic competition has been for traditional drugs.

(d) **Importation of Prescription Drugs:** To introduce price competition, the Secretary shall implement a system to allow **importation of prescription drugs** from countries with comparable safety standards (such as Canada, the EU, and other designated jurisdictions), when those drugs are significantly cheaper and are versions of FDA-approved products. Within 180 days of enactment, the Secretary, using authority under 21 U.S.C. §384 or as provided herein, shall issue regulations to permit licensed wholesalers and pharmacies in the U.S. to import medications from approved foreign sellers, provided that the drugs are manufactured consistent with FDA approval (essentially the same product as sold here or a foreign-approved comparator deemed safe and effective by FDA). Priority for importation will be given to high-cost drugs that lack competition in the U.S. The regulations must ensure drug authenticity and safety through labeling, testing, and tracking requirements. If necessary under current law, the Secretary hereby certifies that importation under this section will pose no additional risk to public health and will significantly reduce costs to American consumers. This certification, combined with the mandated regulations, activates the importation program. The Secretary can also

authorize individuals to import up to a 90-day personal supply of a medication from an approved foreign pharmacy, for personal use, particularly if it's life-saving and unaffordable domestically, so long as it's an FDA-approved or equivalent drug. Should any manufacturer attempt to restrict supply to foreign markets to thwart this importation (for instance, by limiting sales to Canada to prevent re-export), the Secretary and FTC shall investigate for anti-competitive behavior and coordinate with foreign regulators to address such conduct.

(e) **Strengthening the Supply of Generics:** The Secretary, in consultation with the FDA, shall address the issue of generic drug shortages or lack of competition (especially "sole-source" generics that become expensive). Measures may include incentivizing additional manufacturers to produce scarce generic medications (through fast-track approvals, temporary market exclusivity as a reward for entering a shortage market, or government purchase guarantees), and empowering the government to contract manufacturing of critical drugs if the market fails (for example, contracting with domestic compounding pharmacies or generic manufacturers to produce essential medicines in shortage). The Act authorizes the FDA to expedite review of any generic drug application where the drug has either zero or only one manufacturer on the market, as a means to spur competition. The FDA's generic user fee program shall prioritize these critical needs. The Secretary is also authorized to use competitive procurement for multi-source generics under the NHP if needed to leverage lower prices (somewhat akin to a tender system as used in other countries for certain off-patent drugs), provided that at least two suppliers exist to ensure supply security.

(f) **Enforcement and Monitoring:** The FTC, in collaboration with the Department of Justice (DOJ) Antitrust Division and the HHS Office of Inspector General, shall vigorously enforce the provisions of this section. The FTC is granted authority to seek civil penalties for violations of subsection (a) (pay-for-delay) and to treat knowing violations as per se antitrust violations. The HHS Inspector General shall monitor pricing trends and report to the Secretary any suspicious patterns of price spikes or supply manipulation that may indicate anti-competitive conduct. The Secretary and FTC shall jointly submit an annual report to Congress detailing progress on promoting drug competition: including the number of pay-for-delay agreements stopped, reductions in biologic exclusivity periods and biosimilar approvals, the status of drug importation program (with data on cost savings), and any recommendations for further action if companies find new loopholes to maintain monopolies. If additional legislative authority is needed (for example, new penalties or clarifications to patent law), the report should outline those needs.

Through these actions, Congress intends to ensure that the pharmaceutical market serves patients and innovation rather than solely corporate interests, by breaking monopolistic practices and unleashing competitive forces that drive prices down while continuing to reward true breakthroughs.

(End of Title IV)

Title V – Integrated Care and Coordination of Health Services

SEC. 501. INTEGRATED CARE INITIATIVES AND GRANTS.

(a) **Establishment of Integrated Care Programs:** The Secretary of Health and Human Services shall implement new programs and expand existing efforts to **integrate care** across the health care continuum – including primary care, specialty care, mental health care, and social support services – with the goal of improving patient outcomes and experience. Within 12 months of enactment, the Secretary shall create the **Integrated Care Initiative (ICI)**, a framework to encourage providers to form collaborative practice models that address the comprehensive needs of patients, especially those with complex or chronic conditions. Participation in the ICI can take multiple forms, such as:

- **Patient-Centered Medical Homes (PCMH):** Primary care practices that serve as a central home for patients, coordinating all their health needs with a team-based approach. Such practices will receive additional care coordination payments and must meet standards including 24/7 access, use of care plans, and proactive population health management.
- **Accountable Health Teams:** Groups of providers (potentially spanning primary care, mental health, and social work) that formally partner to manage the care of a defined population, with shared accountability for outcomes. These teams might exist within ACOs or as independent networks. The NHP may pay these teams via global budgets or shared savings to incentivize joint responsibility.
- **Integrated Behavioral Health in Primary Care:** The Secretary shall specifically promote models like the Collaborative Care Model, where mental health professionals (psychiatrists, psychologists, counselors) are embedded in primary care settings, and primary care providers have psychiatric consultation support. Payments for behavioral health integration (BHI) shall be made available (e.g., a monthly per-enrollee payment for practices implementing BHI), recognizing the improved outcomes when mental health is treated alongside physical health.

(b) **Grants for Integration Projects:** There is authorized to be appropriated $__ (to be determined by Congress, e.g., $1 billion over 5 years) to fund competitive grants and cooperative agreements with eligible entities (such as health systems, community health centers, rural health clinics, behavioral health clinics, or consortiums of providers) to implement innovative integrated care projects. The Secretary, through agencies like the Center for Medicare & Medicaid Innovation and the Substance Abuse and Mental Health Services Administration (for mental health integration), shall solicit proposals that, for example:

- Create **Integrated Practice Networks** in rural or underserved areas (e.g., linking small primary care offices with telehealth specialty and mental health consults, supported by a regional care coordination hub).
- Develop **Community Health Teams** that pair medical providers with social service providers (like housing specialists, nutritionists, community health workers) to jointly address patient needs.
- Expand the **Certified Community Behavioral Health Clinic (CCBHC)** model, which

provides coordinated outpatient mental health and substance use treatment with primary care screening; grant funds could help CCBHCs connect more formally with primary care practices.
- Pilot **co-location of services** – for instance, placing a pediatric clinic and an adult mental health clinic in the same facility to serve families holistically, or having pharmacists, physical therapists, and dietitians on-site at primary care clinics for one-stop services.

Grant recipients must demonstrate a plan to sustain successful integration efforts beyond the grant period (for example, by transitioning to new payment models or proving cost savings to the NHP). The Secretary shall give priority to proposals that target high-need populations, such as individuals with serious mental illness, frail older adults, or those dually eligible for Medicare and Medicaid (during the transition period), as well as communities with significant health disparities.

(c) **Expansion of Successful Models:** The Secretary shall evaluate the outcomes of the various integrated care pilots and programs (including those launched under Medicare or private sector that show promise) and, if proven to improve care or reduce costs, shall expand such models throughout the National Health Program. For example, if an evaluation finds that a certain type of integrated care clinic reduced hospitalizations for complex patients by X%[10][12], the Secretary could authorize that payment model or clinic type to be a covered benefit nationwide. In doing so, the Secretary can waive applicable provisions of law on a demonstration basis (under CMMI authority) to facilitate expansion, and then seek legislative support to make permanent changes if needed.

(d) **Workforce Development for Integrated Care:** The Act recognizes that integrated care depends on a workforce trained in team-based, holistic care. Therefore, the Secretary shall collaborate with the Department of Education and other relevant bodies to support education and training programs focusing on integrated practice. This includes:
- **Interdisciplinary Training Grants:** Funding academic institutions or teaching hospitals to develop interdisciplinary curricula where medical, nursing, social work, pharmacy, and mental health students/residents learn together how to coordinate care.
- **Expanded Graduate Medical Education (GME):** Directing some of Medicare's GME funding (or NHP equivalent funding) toward residency programs in primary care, geriatrics, and psychiatry that have strong integrated training components (for instance, family medicine residents training alongside behavioral health specialists).
- **Loan Repayment and Fellowships:** Incentivizing providers to enter fields important for integration (primary care physicians, nurse practitioners, physician assistants, clinical social workers, etc.) and serve in integrated or underserved settings through expanded National Health Service Corps loan repayment slots and new fellowships in integrated care (such as a fellowship for internal medicine physicians in hospital-community integration leadership).

These workforce measures aim to ensure enough professionals are available and skilled to deliver the kind of coordinated care envisioned.

(e) **Addressing Social Needs in Health Care Settings:** To truly integrate care, providers need capacity to help patients with non-medical needs that impact health (the social determinants of health). Under the National Health Program, the Secretary shall authorize coverage or reimbursement for certain **health-related social services** delivered as part of care coordination. For instance, if a patient is hospitalized frequently due to homelessness, the program could fund a case manager's efforts to secure housing or temporary housing vouchers as part of a care plan, recognizing that stable housing will reduce medical costs. Similarly, nutrition counseling and connecting food-insecure patients with meal programs could be considered reimbursable preventive care activities. The Secretary can establish a **Social Determinants of Health Innovation Fund** (drawing on prevention funds or integration grants) for local entities to screen for social needs and provide or arrange services (like medical-legal partnerships to address legal issues affecting health, community asthma programs that provide home air quality improvements, etc.). The Secretary shall ensure that any such spending is evidence-informed and coordinates with existing social service programs to avoid duplication. Over time, if these interventions show health and cost benefits, the Secretary may propose making certain services a permanent part of the NHP benefit package or value-based payment adjustments.

SEC. 502. IMPROVING CARE COORDINATION AND HEALTH INFORMATION EXCHANGE.
(a) **Care Coordination Payments:** To encourage providers to spend time coordinating care (which often goes unreimbursed in fee-for-service), the NHP will explicitly pay for care coordination activities. For example, primary care practices will receive a per-member-per-month care coordination fee for each NHP enrollee in their panel, intended to cover tasks like managing referrals, following up on test results, proactively checking on patients with chronic diseases, and communicating with specialists[10]. Similarly, hospitals will receive discharge planning payments when they successfully arrange follow-up appointments and ensure a smooth transition for patients from hospital to home or rehab, as a strategy to cut down on readmissions. The Secretary shall set the amounts and conditions for such payments based on best practices (e.g., requiring documentation of a care plan or transitional care management contact). Providers who demonstrate lower fragmentation of care (for instance, fewer duplicate tests and better patient satisfaction with care continuity) could be eligible for bonus payments or higher fee schedules as an incentive[12]. These payments acknowledge that integrated care requires dedicated effort which should be compensated.

(b) **Interoperability and Health Information Exchange:** As noted in Title III, Section 302(d), robust health IT is the backbone of coordinated care. This section reinforces that the Secretary, through ONC and CMS, will mandate that all participating providers in the NHP utilize interoperable health records. Key actions include:
- By no later than January 1, 2026, all hospitals and clinics receiving payment from the NHP must be capable of sending and receiving summary of care records electronically (using standards like HL7 FHIR APIs) to any other provider involved in a patient's care.
- Information Blocking (defined under 42 U.S.C. 300jj-52) is prohibited; any provider or IT developer who inappropriately blocks information sharing will be subject to penalties (e.g.,

hospitals could face reductions in NHP payments for repeated violations).
- The creation of a **National Health Information Exchange Network** that all providers can plug into, potentially building on existing networks (like eHealth Exchange, CommonWell) but with universal coverage. The NHP will provide resources or a platform so that even small or resource-limited practices can participate without high cost.
- Patients shall have easy access to their own health information through a single unified patient portal or app if possible, covering their interactions across providers (leveraging the aforementioned FHIR API requirement, so patient-authorized apps can aggregate their records).

(c) **Unified Health Records and Patient Identifiers:** The Secretary shall work toward a **unified health record** for each NHP participant, possibly via a national master patient index or unique patient identifier system, to ensure records from different sources merge correctly for the right individual. Congress's prior limitations on HHS developing a unique patient identifier (UPI) are recognized, but given the importance of matching records, if those limits remain, the Secretary shall utilize alternative privacy-protective methods (like probabilistic matching algorithms or voluntary identifiers) to improve record linkage. The aim is that a provider, with patient consent, can retrieve a consolidated medical history from the NHP system that includes key diagnoses, medications, allergies, and recent service use, regardless of where the care was provided, thus truly breaking down silos.

(d) **Multidisciplinary Care Conferences:** The NHP will reimburse for **multidisciplinary team meetings** for complex patients. For example, if a patient with congestive heart failure, diabetes, and depression is struggling, a virtual or in-person conference among their cardiologist, endocrinologist, primary care doctor, and therapist (and possibly a care manager) could be convened to align the treatment plan. Historically, such conferences are not paid for and thus rare; under the NHP, billing codes for care conference time will be established so providers can be paid for these important coordination efforts. Payment for these should require a summary of the meeting and a revised care plan delivered to the patient. Initially, these might focus on high utilizers or those with multiple conditions, but could expand if successful.

(e) **Reduction of Administrative Barriers:** The Secretary shall identify and eliminate unnecessary administrative or regulatory barriers to integrated care. For instance, current insurance prior authorization requirements often impede timely referrals or sharing of information. The NHP should minimize prior authorizations for in-network referrals or certain procedures that are evidence-based. If prior authorization is used (to prevent misuse), it should be uniform and electronically supported across the Program to avoid burden. Similarly, quality reporting requirements will be aligned across programs to avoid providers having to keep multiple records for different payers. One single integrated set of metrics and reporting processes should suffice (as developed under Sec. 302(b) for quality measures). Malpractice safe harbors could be explored: if providers adhere to approved care coordination protocols or clinical guidelines in integrated practice, that might serve as evidence of appropriate care.

(f) **Evaluation:** Within 4 years of enactment, the Government Accountability Office (GAO) or an independent evaluator contracted by HHS shall report to Congress on the progress of care integration under the NHP. Metrics to be evaluated include: patient outcomes for those in integrated models vs. traditional care, patient and provider satisfaction, fragmentation indices (like whether patients see fewer redundant providers or have improved continuity with a primary team), usage of hospitals and emergency departments, and overall costs. The report should highlight successes (for example, reduction in hospital readmissions by X% in integrated care pilots) and areas needing improvement (perhaps IT challenges or workforce shortages in certain fields). It shall also consider feedback from patients regarding their experience navigating the health system (e.g., do they feel it is more "one system" vs. confusing separate entities). Based on findings, the Secretary shall implement recommended adjustments.

By passing Title V, Congress intends to reform the culture and practice of American health care from one that is often siloed and reactive, to one that is **team-based, coordinated, and proactive**, thereby improving health outcomes and addressing patients' comprehensive needs efficiently[10].

(End of Title V)

Title VI – Ending Medical Debt and Protecting Patients' Financial Well-Being

SEC. 601. PROTECTION FROM AGGRESSIVE MEDICAL DEBT COLLECTION.
(a) **Prohibition of Extraordinary Collection Actions:** Health care providers and their affiliated organizations (including hospitals, clinics, physician practices, laboratories, and any entity that bills patients for medical goods or services) that participate in the National Health Program or receive federal funds (including Medicare/Medicaid during the transition, or tax-exempt status) **shall not engage in extraordinary medical debt collection actions** against any individual without first complying with the requirements of this section. "Extraordinary collection actions" (ECAs) are defined as actions including but not limited to: reporting a patient's medical debt to credit reporting agencies; placing a lien on a patient's property or attaching any bank account or other personal property; garnishing a patient's wages or other income; actions that involve selling the debt to a third-party collection agency (except as permitted herein); and civil litigation against patients for unpaid bills.

(b) **Conditions for Any Debt Collection:** Providers may attempt reasonable debt collection (such as sending bills or reminders) for amounts legitimately owed by patients (e.g., cost-sharing under the NHP or non-covered elective services), but before undertaking any ECA or involving any third-party debt collector, the provider must ensure:
1. **Financial Assistance Screening:** The patient has been offered an opportunity to apply for the provider's financial assistance program (as required by Sec. 602) or other available hardship exemptions and has either not responded or been found ineligible. Documentation of either a completed application or reasonable attempts to notify the

patient of assistance options (via multiple methods and in the patient's primary language) shall be required. If the patient is eligible for charity care or discounted care under the provider's policy, the provider must adjust the charges accordingly and not pursue the forgiven amount.
2. **Payment Plan Offer:** The provider has offered the patient a **reasonable payment plan** for the outstanding balance, with monthly payments not to exceed a modest percentage of the patient's disposable income (for instance, no more than 5% of monthly income, though the Secretary may set specific safe harbor percentages). The term of the payment plan should be such that it does not require immediate lump sum payment that could cause hardship. No interest shall accrue on medical debt while a patient is adhering to a payment plan.
3. **Waiting Period:** At least 180 days have passed since the first post-service bill was sent to the patient, during which the provider has attempted to communicate and settle the debt without ECAs. If the patient is actively in communication, that waiting period should extend (so providers are incentivized to work with patients).
4. **Approval by Senior Official:** For hospitals or large provider entities, any decision to proceed with an extraordinary collection (like suing a patient) must be reviewed and approved by a designated senior officer (e.g., the Chief Financial Officer or a committee including patient advocates) to ensure compliance with this Act and avoid overreach.

(c) **Interest Cap:** If a medical debt is eligible to be collected (after satisfying (b)), the interest rate that can be charged on that debt (if any) shall not exceed **3% per annum or the local state's judgment interest rate if lower**[18]. The accrual of interest on medical debt from the date of service until final payment is hereby limited to prevent ballooning debt balances. In fact, providers are encouraged to refrain from interest altogether and many already do; this sets an upper bound in cases where interest might apply (such as a court judgment). Any collection of interest beyond this cap is considered void and against public policy, and the principal of the debt will be deemed satisfied by any excess interest paid.

(d) **No Credit Reporting of Medical Debt:** Consumer credit reporting agencies shall be prohibited from including any information related to **medical debt** collection on credit reports. Medical bills and any delinquencies or collections thereof shall be treated as a separate category of financial obligation that does not reflect creditworthiness for credit purposes. The Fair Credit Reporting Act (15 U.S.C. 1681c) is amended to add medical debt to the list of information that shall not be included in consumer reports. In practical terms, this means even if a hospital sends a bill to collections, it cannot mar a patient's credit history. The Consumer Financial Protection Bureau (CFPB) shall enforce this provision and ensure credit bureaus and debt collectors comply. If any medical collection item is found on a credit report after the effective date, the consumer has the right to dispute it and have it removed expeditiously.

(e) **Ban on Arrest and Jailing:** Under no circumstances shall a patient be subject to arrest or incarceration for failure to pay a medical bill. All states and jurisdictions are urged to abolish any remnants of "debtors' prison" practices for medical debt. Any court orders

that could lead to body attachment or contempt leading to jail time for medical debt nonpayment are contrary to this federal Act and should be deemed invalid. The Attorney General shall work with state court systems to communicate this ban and potentially intervene if violations occur as a civil rights matter.

(f) **Debt Collection Practices and Penalties:** Medical debt collectors (including collection agencies and attorneys) must adhere to the Fair Debt Collection Practices Act (FDCPA) with additional constraints: they must provide a clear notice to patients of their rights under this Act and the provider's financial assistance policy when making contact. They are not allowed to harass or threaten actions that are barred (like credit reporting or arrest). The CFPB and FTC shall treat any abusive or deceptive medical debt collection practice as an unfair/deceptive act under the FDCPA and FTC Act, subject to fines. Patients from whom a prohibited collection action is attempted may bring civil suit for damages (including statutory and punitive damages) and attorneys' fees. Providers who engage in a pattern of violating these provisions (like suing large numbers of low-income patients without screening for assistance) can be sanctioned by HHS, including potential exclusion from the NHP or other federal programs until compliance is corrected. Similarly, tax-exempt hospitals violating these rules risk their 501(c)(3) status under IRS rules (the Act effectively federalizes some of the existing IRS 501(r) requirements and adds teeth).

SEC. 602. HOSPITAL AND PROVIDER FINANCIAL ASSISTANCE REQUIREMENTS.

(a) **Mandatory Financial Assistance Policy:** Each hospital (including critical access hospitals, general acute care, etc.) and any other significant provider entity as determined by the Secretary (for example, large multi-specialty clinics or academic practice plans) that serves patients under the National Health Program must develop, implement, and widely publicize a **Financial Assistance Policy (FAP)** for low-income and hardship cases. At a minimum, the policy must:

1. Provide for **free or reduced-cost care** for individuals with family income up to a certain threshold. The Act sets a baseline that **patients with incomes up to 200% of the Federal Poverty Level (FPL) are eligible for free care** for medically necessary services received from that provider. Those between 200% and 400% FPL must be eligible for care on a sliding fee scale with substantial discounts (for example, at 300% FPL, maybe a 50% discount or only nominal fees). Providers may choose to be more generous than these minimums (and many charitable hospitals already are), but cannot be more restrictive.
2. Consider **catastrophic medical bills** relative to income: Regardless of income level, if a patient's out-of-pocket medical costs at that provider (or cumulatively, if the provider is part of a system that can measure it) exceed a certain percentage of their household income (say 20% in a year, or some threshold defined by the Secretary), the amount above that threshold should be forgiven or reduced to avoid catastrophic burden. This is essentially a backstop for people who might be middle-income but faced a huge bill due to an expensive condition.
3. Explain the **application process** in plain language and allow ample time (at least 240 days from first bill) for patients to apply. It should ideally minimize paperwork, leveraging presumptive eligibility if possible (for instance, if a patient is on SNAP, Medicaid, or other assistance, they are presumed to qualify for free or discounted care).

4. Be approved by the provider's board of directors (if applicable) and reviewed by HHS for compliance. The Secretary can require standardization in parts of these policies to ensure fairness and comparability.

(b) **Notification and Publicity:** Providers must inform patients of the availability of financial assistance in all significant communications about billing. This includes: on all billing statements (with a bold notice like "If you cannot pay this bill, you may qualify for free or reduced-cost care – call ___ or visit ___ for information"); on signage in emergency departments, admissions areas, and billing offices; and on the provider's website with easy access to policy details and application forms in multiple languages common in the community. When communicating verbally about bills, staff should ask if the patient would like to be screened for assistance. The aim is that patients are aware of these options **before** bills become debt. For non-English-speaking or limited-literacy patients, appropriate accommodations must be made to convey this information.

(c) **Limitations on Charges to Assistance-Eligible Patients:** Providers cannot charge patients who qualify for financial assistance more than the amounts generally billed to insured patients (often termed the "Amount Generally Billed" (AGB) under current IRS rules for hospitals). In practical terms, if an uninsured patient qualifies for a discount, their bill after discount should not exceed what the provider would get, on average, from NHP or an insurer for that service. This prevents price gouging of the uninsured or underinsured. The Secretary shall enforce that for those under 200% FPL (free care mandate), the charge is $0 aside from maybe a nominal fee if allowed (like $5 or $10 for some services to discourage misuse, though even that may be waived). For sliding scale patients, their portion is similarly limited.

(d) **Enforcement and Transparency:** Providers must annually report to the Secretary summary statistics on their financial assistance provided: how many patients applied and were approved, total amount of charges forgiven, and demographic breakdowns. This will be made public to ensure accountability (particularly for non-profit hospitals who have a community benefit obligation). If a provider is found to be out of compliance (e.g., not adequately offering or honoring financial assistance), the Secretary will require a corrective action plan. Continued non-compliance could result in penalties, including potential exclusion from NHP reimbursement for extreme cases or referral to IRS for tax status review for non-profit hospitals. The Secretary can also require providers to retroactively forgive debts for patients who should have qualified but were not offered assistance (essentially cleaning up past aggressive collections that violated these policies).

To encourage adherence, the Act leverages existing infrastructure: For example, many states have laws on hospital charity care – this sets a federal floor. The IRS 501(r) rules for charitable hospitals already have some similar requirements; this Act extends equivalent expectations to all major providers and strengthens enforcement.

(e) **Billing Statements and Clarity:** All bills sent to patients by providers must be written in clear, concise language. They should itemize services in understandable terms (no

inscrutable codes without explanation) and clearly show adjustments (like insurance payments, NHP payments, and financial assistance reductions) and the net amount owed by the patient. If any amount is being billed that is later going to be submitted to NHP (e.g., if NHP hasn't processed yet), that should be clarified to avoid confusion. Surprise billing in the sense of out-of-network charges is largely moot if the NHP covers all licensed providers; however, in any scenario where a patient might get a bill from an out-of-network provider (like perhaps if they deliberately seek cosmetic services not covered), the provider must explicitly inform the patient beforehand of estimated charges and that it's not covered, to ensure no surprise. The No Surprises Act of 2020 provisions for emergency and ancillary out-of-network billing are effectively absorbed by NHP's broad coverage, but the ethos remains: patients should not be caught off-guard by charges.

(f) **Monitor and Support:** The Secretary will stand up a **Medical Debt Ombudsman** office within HHS (or assign the duty to an existing consumer assistance program) to help patients navigate these protections. This office will field complaints from patients who feel they're being improperly billed or collected upon, mediate with providers, and guide them to resources like financial assistance. It will also track trends to inform enforcement: for instance, if a particular hospital is the subject of many complaints for suing patients, that hospital can be targeted for investigation.

SEC. 603. MEDICAL DEBT RELIEF PROGRAM.
(a) **Establishment of Relief Program:** The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish a **Medical Debt Relief Program** (MDRP) to forgive or reduce medical debt owed by individuals facing financial hardship or catastrophic health events. The program's aim is to alleviate the existing burden of medical debt that predates or otherwise falls outside the scope of the National Health Program (for example, incurred prior to this Act's reforms or due to costs not covered).

(b) **Scope of Debt Relief:** The MDRP is authorized to purchase and discharge (forgive) medical debt from hospitals, physician groups, third-party debt collectors, and credit owners on behalf of patients who qualify under criteria set by the Secretary. Key parameters:
- Priority should be given to debts owed by households with incomes below a certain threshold (e.g., below 400% FPL) or who have qualified for financial assistance but still had remaining bills, and to debts resulting from emergency or medically necessary care (as opposed to purely elective procedures like cosmetic surgery bills).
- Also prioritized are accounts that have been sent to collections or are on credit reports, to maximize credit score improvement for individuals and relieve stress[15].
- The Secretary is authorized to negotiate bulk buyouts of medical debt portfolios from collection agencies/hospitals at negotiated rates (often pennies on the dollar, given how those markets operate) and then forgive those debts. This mirrors the model of charitable organizations (like RIP Medical Debt) but now with federal backing and scale.

(c) **Application vs. Automatic Criteria:** The Secretary may establish an application process where individuals can apply for debt relief by demonstrating their hardship (e.g., via income documents, medical bankruptcy filings, or other evidence). However, the Secretary should also attempt data-driven identification to automatically target relief. For example, if a person has been means-tested through another program (Medicaid, SNAP, etc.) or if their medical debts exceed a large share of their income, they could be deemed eligible without a burdensome process. The program might, for example, coordinate with credit bureaus or large health systems to find those accounts eligible for purchase and forgiveness.

(d) **Funding:** There are authorized to be appropriated to the Medical Debt Relief Program **such sums as may be necessary** to carry out its operations. For initial implementation, Congress may choose a specific appropriation (e.g., $5 billion) which the Secretary can use to buy and forgive debt. Additionally, the Secretary can accept gifts or donations specifically earmarked for medical debt forgiveness (should philanthropic organizations or individuals wish to contribute). The cost-effectiveness of this approach is notable: since medical debt often trades at a fraction of face value, each federal dollar can wipe out several dollars of nominal debt. The Secretary shall manage the program to maximize relief per dollar spent, focusing on those most in need.

(e) **Tax Treatment and Credit Repair:** Any debt forgiven under the MDRP shall **not** be treated as taxable income to the debtor (the Act may need to amend the Internal Revenue Code to ensure cancellation of medical debt by this federal program is excluded from gross income, similar to how certain student loan forgiveness was handled). The logic is that this is relief of a financial burden, not a windfall that should be taxed. Furthermore, the program will coordinate with credit reporting agencies to remove any negative credit entries associated with debts that have been forgiven through this program, to ensure individuals truly get a fresh start. The Secretary will provide affected individuals with documentation that their debt was forgiven by the program, which they can use to dispute any lingering credit marks, if the program doesn't directly liaise with credit bureaus (preferably it will).

(f) **Outreach:** HHS shall conduct outreach to inform the public about the availability of the Medical Debt Relief Program, particularly in communities and venues where people with large medical debts might be reachable (e.g., through bankruptcy court clinics, community health centers, social service agencies). The aim is that those struggling know that this relief might be available and how to access it.

(g) **Evaluation and Sunset:** The Secretary shall track the outcomes of the MDRP, including total debt forgiven, number of individuals assisted, improvements in those individuals' financial stability (if measurable, possibly via surveys or credit improvements), and any regional or systemic patterns (like if most forgiven debt came from a handful of providers, indicating problems to address at the source). Within 5 years of program start, a report to Congress shall be submitted with these findings and recommendations on whether the program should be continued, expanded, or adjusted. Ideally, as the main provisions of

this Act (like universal coverage and cost protections) take hold, the need for large-scale debt forgiveness will diminish. But for legacy debt and remaining gaps, this program is a crucial bridge.

SEC. 604. REGULATIONS; EFFECTIVE DATES FOR TITLE VI.
The Secretary of Health and Human Services, as well as other relevant federal agencies (such as the Treasury for tax matters and the CFPB/FTC for debt collection/credit reporting enforcement), shall promulgate regulations to implement the provisions of this title within 180 days of enactment. Unless otherwise specified, the patient protections in this title (Sections 601 and 602, regarding collection and financial assistance) shall take effect for any medical bills incurred after 180 days from enactment. However, to provide relief to those currently in collections, Section 601(d) (the credit reporting ban) shall take effect immediately upon enactment, causing credit agencies to purge existing medical collection data within one year. Section 603 (Debt Relief Program) shall be operational as soon as the Secretary can set it up, with the goal of beginning debt purchases within one year. This Title does not preempt state laws that provide equal or greater protections to consumers; rather, it sets a federal floor. States may continue or enact stricter limits on medical debt collection or more generous charity care requirements (for instance, if a state mandates free care up to 300% FPL, that stands). The Secretary shall work with state attorneys general and consumer protection offices to ensure smooth coordination and avoid duplication.

(End of Title VI)

Title VII – Implementation, Funding, and General Provisions

SEC. 701. ADMINISTRATIVE FUNDING AND IMPLEMENTATION RESOURCES.
(a) **Appropriation of Funds for Implementation:** In addition to amounts otherwise made available, there is appropriated to the Department of Health and Human Services (and to subsidiary agencies thereof, such as CMS) out of any money in the Treasury not otherwise appropriated, the sum of **$200,000,000 for each of fiscal years 2025 and 2026**, and **$100,000,000 for each of fiscal years 2027 through 2030**, to remain available until expended. These funds are to be used for the administrative costs of implementing this Act and the transition to the National Health Program. Allowable uses include: hiring and training personnel (such as claims processors, enrollment specialists, drug price negotiators, care coordination program staff); upgrading and expanding information technology systems (for enrollment databases, claims adjudication, health information exchange support, etc.); public education and outreach campaigns about new coverage and patient rights; establishing the infrastructure for drug price negotiations and value-based payment models; and strengthening the capacity of HHS (and partner agencies like the Social Security Administration for enrollment and the IRS for any tax-related functions) to handle the increased scope of the Program. The Secretary shall provide an annual report to Congress on the obligation and expenditure of these implementation funds, including a breakdown of major initiatives and how they support the Act's rollout. The funds in this subsection are designated as an emergency requirement (if Congress so chooses) so that

their expenditure will not count against discretionary budget caps, reflecting the urgent and one-time nature of standing up a comprehensive new program.

(b) **Funding for Medical Debt Relief and Community Programs:** There is further appropriated to the Medical Debt Relief Program (established under Sec. 603) the amount of **$5,000,000,000, to remain available until expended**, for the purpose of purchasing and forgiving medical debts as described. There is also appropriated **$1,000,000,000 for each of fiscal years 2025 through 2029** to the Prevention and Public Health Fund (or a dedicated fund for integrated care and prevention under Title III and V initiatives) to carry out community grant programs, workforce development, and other non-claim costs aimed at strengthening the preventive and integrated aspects of the health system as authorized by this Act. The Secretary shall allocate these funds consistent with Sections 301(b) and 501(b)/(d) (for grants and workforce programs) and report to Congress on outcomes from their use. These appropriations recognize that front-loaded investment in modernization and prevention will yield savings in the long run[19][20].

(c) **Interagency Coordination (OMB Role):** The Office of Management and Budget (OMB) shall facilitate coordination among all federal agencies involved in this Act's implementation[21]. This includes ensuring that the Social Security Administration (SSA) receives necessary funding and instructions to handle enrollment of those approaching age 65 or others who historically went through SSA for Medicare enrollment (since NHP will change that process); coordinating with the Department of Labor to handle any workforce transitions (like those of private insurance industry employees potentially impacted, for whom training funds could be provided via Department of Labor programs); and collaborating with the Treasury on any tax law changes. If any implementing agency identifies a critical need for additional resources specifically attributable to implementing this Act, OMB is directed to support rapid reprogramming or request of funds, including using the President's budget submissions to address those needs[22]. The goal is to prevent bureaucratic bottlenecks: e.g., if CMS needs more call center capacity for questions from the public, or if DOJ needs resources to enforce new drug pricing rules, those should be promptly provided.

SEC. 702. REGULATIONS AND GUIDANCE; INTERIM RULES.

(a) **Interim Final Rules:** Given the comprehensive scope of this Act and the relatively short timelines for implementation, the responsible agencies (HHS primarily, and others as relevant) are authorized to promulgate **interim final regulations** to implement any provision of this Act by the effective dates specified[23]. Such interim final rules shall take effect upon publication (or a specified date) without prior notice and comment if the agency finds that it is impracticable or contrary to public interest to delay implementation (which is presumed here). The agencies shall, however, provide a post-promulgation comment period and are required to finalize the rules after considering public feedback within a reasonable timeframe (ideally no later than 18 months after enactment for major components, as per Title IV of Entitlement Act example)[24]. This ensures that crucial details (like enrollment procedures, provider payment methodologies, negotiation

processes, etc.) can be set up quickly, while still allowing refinement based on stakeholder input after initial rollout.

(b) **Specific Rulemaking Deadlines:】 Without limiting the general authority in (a), the Act sets the following specific deadlines for regulatory action[25]:**
1. By 12 months after enactment: **The Secretary of HHS shall issue regulations or detailed guidance on eligibility and enrollment processes for the NHP (Title II), on the establishment of the drug price negotiation framework (Title IV, Sec. 401), and on hospital/provider financial assistance policies (Title VI, Sec. 602). Also by this time, the Secretary of Labor and Secretary of Treasury shall clarify any changes needed to employer plans and tax treatment due to the shift to NHP.**
2. By the start of 2026: **The Secretary of HHS shall have in place regulations for the expanded drug negotiation and inflation rebates (Title IV) so that by 2026 negotiations for drugs can begin on schedule (the Act envisions price negotiations ramping up in 2026, following the IRA timeline but expanding it). Also by 2026, rules for integrated care models and alternative payment expansions (Titles III & V) should be finalized to guide providers.**
3. By January 1, 2027:** All necessary regulations to fully implement the National Health Program coverage and benefits must be in effect (including but not limited to provider payment schedules, beneficiary cost-sharing design, appeals processes for coverage decisions, etc.). In essence, by the year NHP coverage goes live, all operational rules must be spelled out clearly to the public and providers.

(c) **Public Outreach and Transparency:** The implementing agencies shall engage in robust public outreach while formulating these regulations[26]. Even when using interim rules, they should consult with a range of stakeholders in advance where feasible – including patient advocacy groups, health care providers, states, employers, and insurers (to the extent they remain in supplemental markets) – to gather input. Agencies should also hold public forums or listening sessions in different regions to explain upcoming changes and field concerns. All regulations and guidance documents shall be posted on easily accessible websites, and plain-language summaries provided so the public can understand the changes. The “Medicare & You” handbook, for instance, will be replaced or supplemented by a “Health Program & You” guide, explaining new benefits and any differences from previous Medicare/Medicaid processes, which shall be widely distributed ahead of program launch[27].

SEC. 703. SEVERABILITY.
If any provision of this Act, or the application of such provision to any person or circumstance, is held to be invalid or unconstitutional, the remainder of the Act and the application of its provisions to any other persons or circumstances shall not be affected[28]. Congress declares that it would have enacted this Act and each provision, title, and section thereof, irrespective of the fact that any particular provision or application might be declared invalid. In particular, if any of the drug pricing reforms in Title IV are struck down by a court, that shall not affect the implementation of the universal coverage and other health reforms in Titles I-III and V-VI, and vice versa[29]. All titles of this

Act are intended to function independently to the extent possible; the invalidity of one does not doom the others.

SEC. 704. EFFECTIVE DATES.
Except as otherwise explicitly provided in this Act, this Act and the amendments made by it shall take effect upon enactment[30] for purposes of promulgating regulations, establishing administrative structures, and initiating pilot programs. However, the provision of health care benefits under the National Health Program (Title II) shall commence on **January 1, 2027** ("Full Benefit Date"), which shall be the first day of the first plan year at least one year after enactment, to allow time for setup (if the Act is enacted in 2025, this aligns with a 2-year implementation period). Prior to the Full Benefit Date, the Secretary is authorized and directed to implement provisions as feasible to expand coverage using existing programs: for instance, during 2025-2026, the Secretary may expand Medicare enrollment to those 60 and above, or provide a temporary public option in ACA Marketplaces, as interim steps if appropriate and within budget, to smooth transition to full universal coverage (though such interim measures are not explicitly mandated here, the Secretary can use demonstration authority if helpful and funds allow).

For Titles that can be implemented earlier:
- **Drug Price Negotiation (Title IV):** The Secretary shall begin carrying out the enhanced negotiation authority by 2026 (aligning with the IRA timeline to accelerate beyond it for the first set of drugs), with additional drugs added in subsequent years, and the general negotiation framework fully applied by 2027 to the NHP.
- **Preventive Services improvements (Title III, Sec. 301):** These shall be in effect by January 1, 2026, such that even before NHP starts, all existing federal programs and ACA plans provide the expanded preventive services with no cost-sharing (to the extent not already required), and when NHP starts it will include them from day one.
- **Integrated care pilots and grants (Titles III & V):** Funding becomes available upon enactment, and grants should be awarded starting in 2025 so that models are up and running to integrate into NHP operations by 2027.
- **Ending Medical Debt (Title VI):** As noted in Sec. 604, key protections like no credit reporting and interest caps are effective immediately or within 180 days. Providers are expected to update their financial assistance policies within 180 days and cease aggressive collections accordingly. Debt relief (Sec. 603) will roll out as soon as practical, perhaps forgiving some legacy debts even before NHP begins (symbolically turning a new leaf as the new system comes in).

The Secretary of HHS and the Commissioner of Social Security (for relevant parts of transition) are authorized and directed to take all necessary steps **prior** to these effective dates to ensure smooth implementation[31]. This includes testing systems, conducting pilot enrollment, negotiating drug contracts in advance (so that on Jan 1, 2027, the NHP already has negotiated prices in effect), and educating the public and providers about forthcoming changes. All notices to beneficiaries (like Social Security statements or Medicare mailings) in years leading up to 2027 should include information about the

changes (as the Entitlement Act example suggests for raising retirement age, similarly here for health coverage changes)[32][27].

SEC. 705. AUTHORIZATION OF APPROPRIATIONS AND BUDGETARY TREATMENT.
(a) **General Authorization:** In the event that the specific direct appropriations provided in Sec. 701 are deemed insufficient or not timely for the full implementation of this Act, there are authorized to be appropriated such additional sums as may be necessary to carry out this Act and the amendments made by it[33]. Congress affirms its commitment to ensuring the administering agencies have adequate resources to successfully execute these reforms and directives[34]. Any subsequent appropriations for the National Health Program's operation (beyond the initial implementation funds) should be treated as direct spending on health benefits and thus aligned with the funding mechanisms (trust fund) established; Congress will consider new revenue measures or reallocations to fund the program's ongoing costs, likely outside the scope of this Act's language but to be addressed in budget legislation.

(b) **Budgetary Effects:** Consistent with section 4(d) of the Statutory Pay-As-You-Go Act of 2010, the budgetary effects of this Act (and the savings achieved) shall be entered on the appropriate scorecards as applicable[35]. Congress notes that preliminary analyses indicate this Act will significantly reduce total national health expenditures and could reduce federal deficits over the long-term by streamlining the fragmented system and restraining excessive prices[36]. To the extent that dynamic considerations are allowed, improved national health outcomes and productivity might also positively affect economic growth and revenue. The Office of Management and Budget shall include the budgetary effects of this Act in future baselines and budget submissions, and include the estimated Medicare Trust Fund and overall health system solvency improvements in relevant reports[37] (though Medicare trust fund accounting may be supplanted by the new trust fund framework of the NHP).

(c) **No Reduction in Earned Benefits:** Finally, as a rule of construction, nothing in this Act shall be construed to cut currently earned benefits or coverage for any individual; rather, this Act's intent is to expand and improve coverage while making it sustainable[38]. The transition to a new program should not result in any person losing health services that they would have had but for this Act – any changes should be additions or fair reallocations. Implementing officials shall act consistently with this intent to **"do no harm"** to patient care in the course of these reforms[39]. Any issues of gap or overlap should be resolved in favor of protecting patients from loss of coverage or incurring new costs.

(End of Title VII)

Congressional Findings Regarding Constitutionality: (Optional provision if desired to preempt legal challenges) Congress finds that the provisions of this Act, including the drug price negotiations and expansions of federal health coverage, are a proper exercise of its powers under the Commerce Clause (as the healthcare and insurance industry substantially affect interstate commerce), the Taxing and Spending Clause (to provide for the general welfare in ensuring health care), and other applicable constitutional

authorities. Health care has unique societal importance; this Act addresses national problems that individual states cannot fully resolve, justifying a federal solution. Should any constitutional issues arise, Congress expresses its intent that the Act be interpreted in a manner that upholds its validity to the greatest extent possible.

ENACTMENT CLAUSE: This Act shall become law upon its approval by the President or upon its otherwise becoming law. The reforms herein usher in a new era of health security for the people of the United States, fulfilling the promise that health care is a right and not a privilege, and laying the foundation for a healthier, more just society for generations to come.

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[1] Health Insurance Coverage Projections For The US Population And Sources Of Coverage, By Age, 2024-34 - PubMed

https://pubmed.ncbi.nlm.nih.gov/38889370/

[2] [3] sanders.senate.gov

https://www.sanders.senate.gov/wp-content/uploads/Fact-Sheet_Medicare-for-All-2023.pdf

[4] Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC

https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html

[5] New Report Calls for Urgent Shift from Lifespan to Healthspan as Chronic Disease and Health Care Costs Soar - Association of Schools and Programs of Public Health (ASPPH)

https://aspph.org/news/pressroom/press-release-new-report-calls-for-urgent-shift-from-lifespan-to-healthspan/

[6] [7] [8] [16] [19] [20] [21] [22] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] [33] [34] [35] [36] [37] [38] [39] Entitlement Modernization Act of 2025.pdf

file://file_000000008aa0622fa22b1e3336bb8e46

[9] Pay for Delay | Federal Trade Commission

https://www.ftc.gov/news-events/topics/competition-enforcement/pay-delay

[10] [11] [12] New Studies Reveal that Fragmented Care Persists Despite Efforts to Improve Primary Care and Care Delivery

https://www.mathematica.org/news/new-studies-reveal-that-fragmented-care-persists-despite-efforts-to-improve-primary-care-and-care

[13] [14] 100 Million Americans Have Medical Debt, Study Finds – Ohio Academy of Family Physicians

https://www.ohioafp.org/wfmu-article/100-million-americans-have-medical-debt-study-finds/

[15] [18] States confront medical debt that's bankrupting millions | AP News

https://apnews.com/article/medical-debt-legislation-2a4f2fab7e2c58a68ac4541b8309c7aa

[17] Top Twenty Pay-For-Delay Drugs - PIRG

https://pirg.org/resources/top-twenty-pay-for-delay-drugs/