118TH CONGRESS

1ST SESSION

S. ____

To establish a single national health coverage program known as the SAFECARE Plan, to provide universal essential health coverage for all eligible residents of the United States, to reform health workforce education financing, to reduce administrative waste and medical debt, to reform medical malpractice, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. _____ introduced the following bill; which was read twice and referred to the Committee on _____.

A BILL

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Secure Affordable Federal Essential Care Act" or the "SAFECARE Act".

SEC. 2. TABLE OF CONTENTS.

SEC. 3. CONGRESSIONAL FINDINGS AND PURPOSE.

(a) Findings. Congress finds the following.

(1) In 2024, United States health care spending was approximately 5.3 trillion dollars. This was about 15,474 dollars per person and 18.0 percent of gross domestic product. (Centers for Medicare and Medicaid Services)

(2) Federal subsidies and spending for major health programs and health insurance, including Medicare, Medicaid, the Children's Health Insurance Program, and marketplace subsidies, are projected to total about 25 trillion dollars over the 2024 to 2033 period. (Congressional Budget Office)

(3) The Congressional Budget Office and related analyses project that spending on Social Security and major health care programs will grow from about 10.7 percent of gross domestic product in 2024 to about 14.1 percent by 2054 if current law continues.

(4) Despite high spending, health outcomes in the United States often lag behind other high income countries. Comparative analyses attribute a large portion of the difference to higher prices, administrative costs, and fragmented financing rather than to higher use of services.

(5) Recent estimates suggest that total waste in the health care system, including administrative complexity, pricing failures, overtreatment, and fraud, amounts to between 760 billion and 935 billion dollars per year.

(6) Administrative complexity alone accounts for hundreds of billions of dollars in annual spending, including roughly 200 billion dollars a year on financial transaction related administration and at least half a trillion dollars in broader administrative waste and overhead that does not improve health outcomes.

(7) Medical debt is widespread. A 2022 KFF survey found that about 41 percent of adults had debt due to medical or dental bills. More recent work estimates that 11 to 18 percent of adults currently carry medical debt and that the total burden is on the order of 200 to 220 billion dollars.

(8) Analyses of credit records and survey data show that medical debt is a major contributor to housing instability, delayed care, and financial distress, including among insured households.

(9) Nearly one third of national health expenditures are for hospital care alone, which totaled about 1.5 trillion dollars in 2023. Rising hospital prices and complex cost shifting add to household and employer burdens.

(10) Per capita health care expenditures are projected to grow from about 16,570 dollars in 2024 to approximately 24,200 dollars by 2033 if current trends continue. This implies an average annual per capita growth rate of about 4.6 percent, which outpaces wage growth for many workers and threatens fiscal stability.

(11) Medical education debt is a significant barrier to balanced workforce supply. Recent data show that typical medical school graduates carry debts around 200,000 dollars or more, which pushes them toward higher paying specialties and away from primary care and underserved areas.

(12) Persons who are physically present in the United States, regardless of status, can spread contagious disease if they do not receive basic emergency and public health services. Failure to provide such care endangers citizens and lawful residents and increases long term costs.

(13) Current systems for detecting and punishing fraud in health care are fragmented. Each payer sees only a partial picture. This allows bad actors to move from program to program and to exploit gaps in oversight.

(14) A single national payer for essential care, with a unified risk pool and claims platform, can reduce waste, simplify administration, improve bargaining power, and stabilize coverage across life events, while still allowing room for private supplemental options.

(15) Malpractice coverage and defensive medicine together represent a measurable share of United States health care spending. Major reviews estimate that the combined costs of malpractice premiums, litigation, and defensive medicine practices may account for between 2 and 3 percent of total health spending. This is roughly 100 billion to 150 billion dollars per year. These costs fall unevenly on high risk specialties and do not always track clear gains in patient safety.

(16) In many other developed systems, national malpractice rules combine three elements. Full compensation of documented economic losses. Predictable limits on extreme noneconomic awards. And strong incentives for providers to follow evidence based clinical guidelines.

(17) Predictable national malpractice rules that preserve full compensation for economic harm, limit extreme noneconomic awards, and create safe harbors for adherence to evidence based clinical standards issued by a transparent national board, can reduce defensive medicine and premium spikes while preserving meaningful remedies for patients who experience preventable

harm.

(b) Purpose. The purpose of this Act is to

(1) establish a SAFECARE Plan that provides a universal floor of essential health coverage for every legal resident, independent of employment or marital status,

(2) replace most existing basic health insurance arrangements with a single national payer for essential care, financed through employer and employee payroll contributions and other existing health revenues,

(3) protect households from financial ruin due to illness through strict annual caps on out of pocket costs and a program to redeem and cancel legacy medical debt,

(4) reform health workforce education costs through tuition caps, scholarships tied to service, and structured loan forgiveness,

(5) consolidate data and enforcement authority to detect, prevent, and punish fraud and abuse,

(6) maintain a limited safety net for emergency and public health services for non members, for the protection of the public,

(7) reform medical malpractice liability to stabilize provider costs, discourage defensive medicine, and preserve patient access to fair compensation for real harm,

(8) reduce prescription drug and biologic prices through a national formulary and most-favored-nation pricing linked to prices in comparable developed nations, and

(9) manage the transition from current arrangements to the SAFECARE Plan through a staged schedule that preserves continuity of care.

SEC. 4. DEFINITIONS.

In this Act:

(1) Secretary. The term Secretary means the Secretary of Health and Human Services.

(2) Plan. The term SAFECARE Plan or Plan means the program established under title I.

(3) Legal resident. The term legal resident means a citizen of the United States, a lawful permanent resident, or an alien lawfully present in the United States, as defined by the Secretary in regulations that are consistent with Federal immigration law.

(4) Plan member. The term Plan member means any legal resident enrolled in the Plan under title III.

(5) Essential health services. The term essential health services means medically necessary services that are included in the national benefit floor described in section 104.

(6) Provider. The term provider means any individual or entity that furnishes health services, including hospitals, clinics, physicians, nurse practitioners, physician assistants, mental and behavioral health professionals, dentists, optometrists, pharmacists, and allied health professionals.

(7) Non member. The term non member means a person physically present in the United States who is not a legal resident and is not enrolled as a Plan member, except as provided in the Bridge option under section 603.

(8) Trust Fund. The term SAFECARE Trust Fund or Trust Fund means the fund established under section 201.

(9) Income. The term income means adjusted gross income, as defined in the Internal Revenue Code of 1986, with such modifications as the Secretary of the Treasury may prescribe for purposes of this Act.

(10) Payroll. The term payroll means wages, salaries, and other compensation that are subject to payroll tax under the Internal Revenue Code of 1986, including net earnings from self employment.

TITLE I. ESTABLISHMENT OF THE SAFECARE PLAN

SEC. 101. ESTABLISHMENT.

(a) Program. There is established within the Department of Health and Human Services a program to be known as the SAFECARE Plan.

(b) Function. The Plan shall

(1) provide coverage for essential health services for all Plan members,

(2) pay participating providers for covered services, and

(3) coordinate with existing Federal, State, and private systems during the transition period set forth in title X.

SEC. 102. ADMINISTRATION.

(a) Lead agency. The Secretary shall administer the Plan through the Centers for Medicare and Medicaid Services or a successor agency designated by the Secretary.

(b) Advisory bodies. The Secretary may establish advisory councils on benefits, workforce, payment policy, fraud control, medical liability, and other domains. These councils shall include representatives of patients, providers, employers, and States.

SEC. 103. UNIVERSAL ENTITLEMENT.

(a) Entitlement. Every legal resident of the United States is entitled to enrollment in the Plan and to coverage for essential health services, subject to the provisions of this Act.

(b) Nondiscrimination. Coverage and payment shall not vary because of health status, age, sex, race, income, employment, marital status, or prior use of services.

SEC. 104. ESSENTIAL HEALTH SERVICES.

(a) Benefit floor. The Plan shall cover, at a minimum, the following essential health services.

(1) Primary and preventive care, including routine office visits, screenings, and vaccinations.

(2) Specialty care and consultations.

(3) Emergency and trauma care.

(4) Inpatient and outpatient hospital services.

(5) Maternity, perinatal, and newborn care.

(6) Pediatric services, including basic dental and vision.

(7) Mental health and substance use disorder services, including outpatient and inpatient treatment and medications.

(8) Rehabilitative and habilitative services and devices, including physical, occupational, and speech therapy.

(9) Chronic disease management.

(10) Medically necessary diagnostic imaging and laboratory services.

(11) Medically necessary prescription drugs and biologics, subject to a national formulary and the pricing requirements in section 405.

(12) Adult dental services and vision services, including routine preventive care and medically necessary restorative or corrective services, under standards set by the Secretary.

(b) Preexisting conditions. The Plan shall not exclude or limit coverage of any essential health service because such service is related to a preexisting condition.

(c) Supplemental services. The Secretary may define categories of non essential services that may be offered as supplemental coverage, including elective cosmetic procedures, concierge amenities, and similar items, provided that such services are not required for medical necessity.

SEC. 105. LIMITATION ON DUPLICATIVE PRIVATE COVERAGE.

(a) Prohibition on sale of duplicative basic coverage. No private health insurer or health benefit plan may sell coverage that duplicates essential health services for Plan members.

(b) Scope of allowed private coverage. Private entities may sell supplemental coverage that offers services or amenities beyond the essential benefit floor, such as private rooms, elective cosmetic procedures, or reduced waiting times, so long as such coverage does not

(1) deny or delay access to essential services,

(2) condition access to essential services on purchase of supplemental coverage, or

(3) undermine the stability of the Plan risk pool.

(c) Enforcement. The Secretary and the Secretary of the Treasury shall enforce this section through plan approval, tax rules, and civil monetary penalties.

TITLE II. FINANCING AND THE SAFECARE TRUST FUND

SEC. 201. SAFECARE TRUST FUND.

(a) Establishment. There is created in the Treasury a trust fund to be known as the SAFECARE Trust Fund.

(b) Credits to the Trust Fund. The Trust Fund shall be credited with

(1) amounts equivalent to employer contributions required under section 202,

(2) amounts equivalent to employee and self employment contributions required under section 203,

(3) amounts transferred or credited from integrated Federal and State programs as provided in title X and section 205, and

(4) any other amounts appropriated to the Trust Fund.

(c) Expenditures. Amounts in the Trust Fund shall be available without fiscal year limitation for

(1) payment for essential health services furnished to Plan members,

(2) administration of the Plan,

(3) programs under titles V, VI, VII, VIII, and IX, and

(4) other activities authorized by this Act.

SEC. 202. EMPLOYER HEALTH CONTRIBUTION.

(a) In general. For each calendar year beginning on or after the main implementation date specified in section 1103, every employer shall pay a National Health Employer Contribution with respect to the payroll of such employer.

(b) Standard rate. The standard contribution rate shall be 8.0 percent of payroll.

(c) Small employer rate. Congress may provide a reduced rate for employers with annual payroll below a threshold specified in law to protect small businesses.

(d) Replacement of private premiums. The contribution required under this section is intended to replace employer expenditures on basic health insurance premiums. Employers shall not be required to maintain separate basic coverage for essential services, but may offer supplemental coverage as allowed under section 105.

SEC. 203. EMPLOYEE HEALTH CONTRIBUTION AND WITHHOLDING.

(a) In general. For each taxable year beginning on or after the main implementation date specified in section 1103, every individual who is a Plan member shall pay an employee health contribution.

(b) Wage base and self employment. The contribution under this section shall apply to

(1) wages, as defined in section 3121(a) of the Internal Revenue Code of 1986, and

(2) net earnings from self employment, as determined under section 1402(a) of such Code.

(c) Rate.

(1) Employee rate. The employee health contribution rate shall be 3.5 percent of amounts described in subsection (b)(1), applied from the first dollar, with no minimum income threshold.

(2) Self employed rate. In the case of amounts described in subsection (b)(2), the rate shall be 11.5 percent, applied from the first dollar.

(d) Withholding and payment.

(1) Wages. The contribution on wages shall be collected by withholding by the employer in the same manner as payroll taxes are withheld, and shall be paid to the Treasury at the same times and in the same manner as required for other employment taxes.

(2) Self employment. The contribution on net earnings from self employment shall be paid by the taxpayer in the same manner as self employment taxes.

(e) Replacement of private premium payments. The employee health contribution is intended to replace private expenditures on basic health insurance premiums and deductibles for essential care.

SEC. 204. POINT OF SERVICE COST SHARING, PROHIBITION ON DEDUCTIBLES,

AND ANNUAL CAPS.

(a) No deductibles and no coinsurance. The Plan shall not impose deductibles or coinsurance for essential health services. Any point of service cost sharing under this section shall be in the form of fixed copayments only.

(b) Children and low income households. Plan members who are under age 18, and Plan members in households with income below 200 percent of the Federal poverty level, shall receive essential health services with no point of service copayments.

(c) Standard copayments. For Plan members not described in subsection (b), the Secretary may establish modest fixed copayments for certain non emergency services, subject to the annual cap in subsection (d). The Secretary shall design copayments to avoid discouraging preventive care and clinically indicated treatment.

(d) Annual cap.

(1) In general. Each Plan member shall have a fixed annual cap on total point of service copayments for essential health services.

(2) Initial cap. The initial cap shall be 750 dollars per person per year in 2026 dollars.

(3) Indexing. The cap shall be indexed annually to growth in median wages, under a methodology specified by the Secretary.

(4) After cap reached. After the cap is reached for a member, the Plan shall pay 100 percent of covered essential health services for that member for the rest of the year.

(e) Per person rule. The cap applies per individual and shall not increase due to marriage, household composition, or enrollment of dependents.

SEC. 205. REPLACEMENT OF MEDICARE HOSPITAL INSURANCE PAYROLL

TAXES AND COORDINATION WITH EXISTING FEDERAL HEALTH REVENUES.

(a) Replacement of Hospital Insurance payroll taxes. Beginning on the main implementation date, the Hospital Insurance portion of employment taxes under the Internal Revenue Code of 1986 shall be reduced to 0 percent for wages and self employment income that are subject to contributions under sections 202 and 203 of this Act.

(b) Conforming amendments.

(1) Employee Hospital Insurance tax. Section 3101(b)(1) of the Internal Revenue Code of 1986 is amended by striking "1.45 percent" and inserting "0 percent" for remuneration paid on or after the main implementation date.

(2) Employer Hospital Insurance tax. Section 3111(b)(1) of the Internal Revenue Code of 1986 is amended by striking "1.45 percent" and inserting "0 percent" for remuneration paid on or after the main implementation date.

(3) Self employment Hospital Insurance tax. Section 1401(b)(1) of the Internal Revenue Code of 1986 is amended by striking "2.9 percent" and inserting "0 percent" for taxable years beginning on or after the main implementation date.

(c) Coordination with remaining Federal health revenues. Beginning on the first day of the first calendar year that starts at least two years after the date of enactment, specified portions of other existing Federal health related tax revenues and program receipts, as determined by Congress, may be credited to the Trust Fund.

(d) Consolidation of program budgets. As programs are integrated into the Plan under title X, their budget authority for essential health services shall be consolidated into the Trust Fund.

(e) No double payroll charge. It is the intent of Congress that, beginning on the main implementation date, the employer and employee Hospital Insurance payroll tax is replaced by the contributions under sections 202 and 203, and is not imposed in addition to them.

SEC. 206. TRUST FUND RESERVE STABILIZATION AND AUTOMATIC RATE

ADJUSTMENTS.

(a) Purpose. The purpose of this section is to maintain a stable Trust Fund reserve sufficient to address unexpected costs and economic fluctuations, without deficit financing.

(b) Reserve target band. The Secretary shall administer the Trust Fund to maintain a reserve ratio within a target band of not less than 5 percent and not more than 10 percent.

(c) Reserve ratio defined. For purposes of this section, the term "reserve ratio" means the ending Trust Fund balance for a fiscal year divided by projected Trust Fund outlays for the immediately following fiscal year, as determined by the Chief Actuary of the Centers for Medicare and Medicaid Services.

(d) Automatic upward adjustment. If the Chief Actuary determines that the reserve ratio for a fiscal year is below 5 percent, then for the following calendar year the rates under sections 202 and 203 shall be increased as follows:

(1) Employer rate increase. The rate in section 202(b) shall increase by 0.20 percentage points.

(2) Employee rate increase. The rate in section 203(c)(1) shall increase by 0.10 percentage points.

(3) Self employed rate increase. The rate in section 203(c)(2) shall increase by 0.30 percentage points.

(e) Automatic downward adjustment. If the Chief Actuary determines that the reserve ratio for a fiscal year is above 10 percent, then for the following calendar year the rates under sections 202 and 203 shall be decreased as follows:

(1) Employer rate decrease. The rate in section 202(b) shall decrease by 0.20 percentage points.

(2) Employee rate decrease. The rate in section 203(c)(1) shall decrease by 0.10 percentage points.

(3) Self employed rate decrease. The rate in section 203(c)(2) shall decrease by 0.30 percentage points.

(f) Annual adjustment limits. In any single year, the total adjustment under subsection (d) or (e) shall not exceed:

(1) 0.60 percentage points for the employer rate,

(2) 0.30 percentage points for the employee rate, and

(3) 0.90 percentage points for the self employed rate.

(g) Notice and publication. Not later than November 15 of each year, the Secretary shall publish in the Federal Register the reserve ratio determination and any rate adjustments for the following year.

(h) Congressional override. Congress may override an automatic adjustment for a year by enactment of a law that expressly provides an alternative rate schedule for that year.

TITLE III. ELIGIBILITY, ENROLLMENT, AND CONTINUITY

SEC. 301. ELIGIBLE INDIVIDUALS.

(a) Full Plan members. Every legal resident of the United States is eligible to be a full Plan member.

(b) Non members. Non members are not Plan members, except as provided for the Bridge option in section 603.

SEC. 302. AUTOMATIC ENROLLMENT.

(a) Procedures. The Secretary shall establish procedures to automatically enroll legal residents as Plan members, using existing Federal and State records such as Social Security, immigration, and tax records.

(b) No opt out of essential floor. A legal resident may not opt out of the essential benefit floor, although a resident may decline optional supplemental features.

SEC. 303. IDENTIFICATION AND RECORDS.

(a) Plan identifier. Each Plan member shall be assigned a unique Plan identifier. The Secretary may use an existing Federal identifier if appropriate.

(b) Privacy. The Secretary shall maintain secure electronic records of enrollment and claims. Health data shall be protected by privacy laws and shall not be used for immigration enforcement or non health purposes.

SEC. 303A. DATA SYSTEMS READINESS, INCREMENTAL DEPLOYMENT, AND CERTIFICATION.

(a) Claims and enrollment systems. The Secretary shall develop and deploy the enrollment, eligibility verification, claims intake, claims adjudication, payment, and program integrity systems necessary to administer the Plan.

(b) Incremental deployment. The Secretary shall deploy Plan systems in phases, including pilots and regional rollouts, to ensure continuity of care and to reduce implementation risk.

(c) Independent certification of readiness.

(1) In general. Not later than 180 days before the start of automatic enrollment under section 1005(b), the Secretary shall obtain an independent certification that core enrollment and claims systems are capable of operating at scale.

(2) Certifying entities. The certification shall be performed by the Inspector General of the Department of Health and Human Services, in consultation with the Government Accountability Office, or by an independent entity designated by them.

(3) Criteria. Certification shall assess at minimum:

(A) cybersecurity and privacy controls,

(B) identity and eligibility matching accuracy,

(C) claims throughput and payment timeliness,

(D) error rates and appeals handling capacity,

(E) disaster recovery and continuity planning, and

(F) interoperability with State and Federal data sources required for enrollment and coordination.

(d) Contingency authority.

(1) If certification under subsection (c) is not obtained, the Secretary shall delay the affected phase of automatic enrollment for not more than 12 months and shall implement a corrective action plan.

(2) During any such delay, individuals shall retain existing coverage and protections, and the Secretary shall prioritize enrollment of uninsured individuals and individuals in integrated Federal programs for whom readiness is certified.

(e) Transparency.

(1) Public dashboard. The Secretary shall maintain a public dashboard reporting implementation progress, major milestones, system performance metrics, and independent audit findings.

(2) Reports. Not later than 90 days after enactment and every 180 days thereafter until full implementation, the Secretary shall submit to Congress a report describing progress, risks, and mitigation steps.

SEC. 304. CONTINUITY OF COVERAGE.

(a) Independence from employment. Plan membership shall not terminate or change solely because a member gains or loses employment, changes employers, or changes hours.

(b) Independence from residence within United States. Plan membership shall remain in force when a member moves from one State to another within the United States.

TITLE IV. PROVIDER PARTICIPATION, PAYMENT, AND PRESCRIPTION DRUG

PRICING

SEC. 401. PARTICIPATION AGREEMENTS.

(a) Requirement. A provider that seeks payment from the Plan shall enter into a participation agreement with the Secretary.

(b) Terms. The agreement shall require the provider to

(1) accept Plan payment as payment in full for essential health services, subject to authorized copayments,

(2) comply with Plan billing standards and data reporting requirements,

(3) comply with nondiscrimination and access standards, and

(4) cooperate with audits and fraud control activities.

SEC. 402. PAYMENT METHODOLOGIES AND RATE SETTING.

(a) Methods. The Plan may pay providers using fee schedules, bundled payments, global budgets, capitation, or other methods that support access, quality, and cost control.

(b) Rate setting. Payment rates shall be set in a transparent manner. The Secretary shall consider

(1) the reasonable costs of efficient providers,

(2) the need to maintain access in rural and underserved areas, and

(3) the overall financial condition of the Trust Fund.

(c) Minimum payment floors.

(1) In general. For essential health services furnished on or after the main implementation date, the Secretary shall set national base rates that are not less than the following percentages of the corresponding Medicare payment amounts for the same or comparable services, as determined by the Secretary:

(A) Inpatient hospital services: 115 percent.

(B) Outpatient hospital services: 115 percent.

(C) Physician and practitioner professional services: 110 percent.

(D) Clinical laboratory services: 105 percent.

(E) Imaging and diagnostics paid under fee schedules: 110 percent.

(F) Skilled nursing facility and home health services: 110 percent.

(2) Geographic adjustments. The Secretary shall apply geographic adjustments and special add on payments to preserve access in high cost urban areas and in rural and frontier areas.

(d) Rural and safety net stability.

(1) Global budgets. The Secretary shall establish optional global budget payment arrangements for critical access hospitals, rural hospitals, and designated safety net hospitals.

(2) Access protection. The Secretary shall ensure that payment methods under this section do not cause unreasonable reductions in access to emergency services, maternity services, trauma services, or essential specialty services in any region.

(e) Annual access review.

(1) Review. The Secretary shall conduct an annual access review by region and by specialty.

(2) Corrective action. If the review finds a material access shortage attributable to payment rates, the Secretary shall implement corrective adjustments within 180 days.

SEC. 403. UNIFIED BILLING AND PROHIBITION OF SURPRISE BILLING.

(a) Standard billing format. The Secretary shall adopt a single standard electronic billing format for claims for essential health services.

(b) Surprise billing ban. A provider may not bill a Plan member for amounts above authorized copayments for covered essential services.

SEC. 404. REDUCTION OF ADMINISTRATIVE BURDEN.

The Secretary shall design billing, documentation, and reporting requirements to minimize the time that providers spend on administrative tasks that do not contribute to patient care, consistent with fraud prevention and program integrity.

SEC. 405. NATIONAL FORMULARY NEGOTIATION AND

MOST-FAVORED-NATION PRESCRIPTION DRUG PRICING.

(a) National formulary authority. The Secretary shall establish and maintain a national formulary for prescription drugs and biologics covered as essential health services.

(b) Negotiated net price requirement. As a condition of coverage on the formulary, a manufacturer shall agree to provide the drug or biologic to the Plan at a negotiated net price.

(c) Most-favored-nation ceiling. The negotiated net price for a formulary drug or biologic shall not exceed the International Reference Price for that drug or biologic, except as provided in subsection (f).

(d) International Reference Price defined. The term International Reference Price means the lowest net price, net of all rebates, discounts, chargebacks, and other price concessions, available for the same drug, strength, and dosage form in any member country of the Organisation for Economic Co-operation and Development with gross domestic product per capita not less than 60 percent of that of the United States, as determined by the Secretary.

(e) Data reporting and audit.

(1) Reporting. Manufacturers shall report to the Secretary the net prices described in subsection

(d) in such form as the Secretary shall require.

(2) Audit and penalties. Such reporting shall be subject to audit. A manufacturer that materially misreports prices or concessions shall be subject to civil monetary penalties and other remedies as provided by law.

(f) Limited exception for access.

(1) In general. The Secretary may temporarily permit a negotiated net price above the International Reference Price only if the Secretary makes a written determination, published in the Federal Register, that

(A) the drug or biologic has no clinically appropriate therapeutic alternative for the indicated use, and

(B) failure to grant the exception would likely cause significant and immediate harm to patient access.

(2) Duration. Any exception under this subsection shall be limited to not more than 24 months and may be renewed only upon a new written determination.

(g) Enforcement. If a manufacturer declines to comply with this section, the Secretary may exclude the drug or biologic from the formulary and may impose alternative payment limits or other remedies as authorized by law.

TITLE V. HEALTH WORKFORCE AND EDUCATION REFORM

SEC. 501. TUITION CAPS FOR HEALTH PROFESSIONS PROGRAMS.

(a) Condition on Federal participation. Any educational institution that

(1) receives Federal research funds, or

(2) is eligible for Federal student loan programs, or

(3) receives Plan payments for clinical training and that offers health professions programs covered by this title, shall comply with tuition caps.

(b) Caps. The Secretary, in consultation with the Secretary of Education, shall set maximum annual tuition amounts. For example

(1) for medical degree programs leading to MD or DO, a cap of not more than 15,000 dollars per academic year in 2026 dollars, and

(2) for core nursing and allied health programs, a cap of not more than 10,000 dollars per academic year in 2026 dollars. The caps shall be indexed annually to a health education cost index defined by regulation.

(c) Non compliant institutions. An institution that does not comply with the caps shall be ineligible for the Federal funds and Plan payments described in subsection (a), and its students shall be ineligible for the grant and service scholarship programs under section 502.

(d) Coordination with education support payments. The Secretary shall implement tuition caps under this section together with the Health Professions Education Support Payments under section 501A to prevent disruption of training capacity.

SEC. 501A. HEALTH PROFESSIONS EDUCATION SUPPORT PAYMENTS.

(a) In general. The Secretary, in consultation with the Secretary of Education, shall make Health Professions Education Support Payments to eligible institutions to ensure that tuition caps under section 501 do not reduce the ability of such institutions to provide high quality education and clinical training.

(b) Eligible institutions. An institution is eligible if it complies with tuition caps under section 501 and participates in the clinical training and workforce goals of this title.

(c) Amount.

(1) Base formula. The Secretary shall pay an amount equal to the difference between

(A) allowable educational costs per student as determined under regulations, and

(B) capped tuition and mandatory fees collected per student under section 501.

(2) Guardrails. Allowable costs shall exclude excessive executive compensation, non educational real estate expansion, and unrelated administrative growth as defined by regulation.

(d) Performance conditions. Payments under this section shall be conditioned on measurable outcomes, including graduation rates, board or licensure pass rates, and placement into priority specialties or priority service areas.

(e) Anti gaming. The Secretary shall audit institutions for cost inflation and shall reduce or recoup payments for unreasonable cost growth.

SEC. 502. GRANT AND SERVICE SCHOLARSHIP PROGRAMS.

(a) Grants. The Secretary shall provide grants to eligible students in approved health professions programs to cover tuition up to the caps and reasonable education related expenses.

(b) Service obligation. As a condition of receiving grants, a student shall agree to serve for a period of not less than five years and not more than seven years in Plan covered roles. Priority shall be given to service in primary care, rural and frontier areas, and underserved urban communities, and in high need specialties such as psychiatry and emergency medicine.

SEC. 503. WORKFORCE RELIEF LOAN FORGIVENESS PROGRAM.

(a) Establishment. The Secretary shall establish a Workforce Relief Loan Forgiveness Program to provide forgiveness of qualifying educational loans for existing health professionals.

(b) Amount. For each year of full time qualifying service in designated roles or areas, a participant shall receive forgiveness of a fixed amount of outstanding principal. For example, 30,000 dollars per year for physicians and 15,000 dollars per year for nurses and allied professionals, up to a maximum of ten years.

(c) Focus. The Secretary shall focus the Program on professionals with high debt burdens and on areas with shortages of providers.

SEC. 504. PRIORITY SERVICE AREAS AND SPECIALTIES.

The Secretary shall define and update a list of priority geographic areas and specialties based on access, outcomes, and workforce data. Scholarship and loan forgiveness incentives shall be targeted to these priorities.

TITLE VI. NON MEMBER CARE AND SAFETY NET

SEC. 601. SAFETY NET CARE FUND.

(a) Establishment. Within the Trust Fund there is established an account to be known as the Safety Net Care Fund.

(b) Use. The Safety Net Care Fund shall be used to reimburse providers for services described in sections 602 and 603.

SEC. 602. EMERGENCY, MATERNITY, CONTAGIOUS DISEASE, AND LIMITED

PUBLIC HEALTH PRIMARY CARE SERVICES FOR NON MEMBERS.

(a) Required services. Hospitals and other designated providers shall furnish to any person physically present in the United States, regardless of status or ability to pay,

(1) emergency stabilizing care,

(2) essential maternity and newborn care,

(3) diagnosis and treatment of serious contagious diseases, and

(4) limited public health primary care, including screening, vaccination, and outpatient diagnosis and treatment for communicable diseases of public health concern and related primary care services necessary to prevent transmission, as defined by the Secretary.

(b) Reimbursement. The Plan shall reimburse providers for such services through the Safety Net Care Fund at rates established by the Secretary.

SEC. 603. SAFECARE BRIDGE OPTION.

(a) Bridge coverage. The Secretary may establish a Bridge tier of limited coverage that allows certain long term non citizens, including some non members with at least five years of proven residence and tax compliance, to buy into or receive subsidized coverage that is less than full Plan membership but that includes preventive and primary care.

(b) Firewall. Health data gathered under the Plan and the Bridge option shall not be shared with immigration enforcement authorities, except as ordered by a court for a criminal investigation unrelated to civil immigration violations.

(c) Clarification. Nothing in this section shall be construed to limit required services under section 602(a)(4).

TITLE VII. MEDICAL DEBT REDEMPTION

SEC. 701. MEDICAL DEBT REDEMPTION FACILITY.

(a) Establishment. The Secretary shall establish a Medical Debt Redemption Facility within the Department of Health and Human Services.

(b) Funding and authority.

(1) In general. For each of the first 10 fiscal years beginning on or after the main implementation date, there are authorized to be transferred from the Trust Fund to the Facility not less than 5,000,000,000 dollars and not more than 15,000,000,000 dollars per year, as needed to meet the objectives of this title.

(2) Purchasing efficiency goal. The Facility shall seek to acquire eligible medical debt at the lowest feasible cost as measured by cents paid per dollar of face value, consistent with verification and consumer protections.

(3) Report. Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress stating

(A) total face value acquired,

(B) total price paid,

(C) average cents per dollar paid,

(D) total debt cancelled, and

(E) remaining estimated stock of eligible medical debt.

(c) Objective. The Facility shall prioritize actions intended to eliminate the majority of eligible legacy medical debt within the first 10 fiscal years, subject to availability of portfolios for purchase at reasonable market prices.

SEC. 702. ACQUISITION AND CANCELLATION OF MEDICAL DEBT.

(a) Authority to acquire. The Facility may purchase portfolios of medical debt at fair market value from providers, collectors, and debt buyers.

(b) Priority. The Facility shall give priority to portfolios that

(1) consist mainly of debt owed by households below or near the median income, or

(2) involve older debts, or

(3) have already been sold for collection at a deep discount.

(c) Cancellation. Debt acquired under this section shall be cancelled. No person may attempt to collect such debt.

SEC. 703. CONSUMER PROTECTIONS.

The Secretary shall ensure that

(1) affected individuals are notified of cancellation in clear language, and

(2) credit reporting agencies update records to reflect that such debt has been forgiven and shall not be reported as active debt.

TITLE VIII. FRAUD, WASTE, AND ABUSE CONTROLS

SEC. 801. NATIONAL HEALTH CLAIMS DATA PLATFORM.

(a) Establishment. The Secretary shall create a National Health Claims Data Platform to receive, store, and analyze claims data for services funded under this Act.

(b) Standards. The Secretary shall establish uniform data and transaction standards and shall require participating providers and contractors to submit claims in accordance with those standards.

SEC. 802. REAL TIME FRAUD DETECTION AND PRE PAYMENT REVIEW.

(a) Analytics. The Secretary shall implement analytic systems, including statistical and machine learning methods, to identify anomalous billing patterns in near real time.

(b) Pre payment review. The Secretary may withhold payment of claims that are flagged as high risk until a review is completed.

SEC. 803. FEDERAL FELONY PENALTIES FOR SYSTEMIC FRAUD.

(a) Offense. Any person who knowingly executes or attempts to execute a scheme to defraud the Plan or the Trust Fund in an amount that exceeds 100,000 dollars in any twelve month period commits a Federal offense.

(b) Penalties. The offense shall be punishable by imprisonment, fines, and mandatory forfeiture of property derived from the offense, in a manner similar to penalties for major health care fraud and wire fraud under existing law.

SEC. 804. PERFORMANCE, VALUE, AND INTEGRITY MONITORING USING

ADVANCED ANALYTICS AND AI.

(a) Establishment. The Secretary shall establish a continuous performance monitoring program for the SAFECARE Plan, to be known as the National Health Integrity, Efficiency, and Value Program.

(b) Purpose. The purposes of the Program are to

(1) detect and reduce fraud, waste, and abuse,

(2) measure and reduce administrative burden,

(3) identify high value care and low value care patterns,

(4) improve payment accuracy and timeliness,

(5) monitor access, quality, and outcomes, and

(6) support evidence based benefit design and clinical standards over time.

(c) Use of advanced analytics and AI tools. The Secretary shall deploy modern analytic tools, including state of the art statistical methods and machine learning or AI systems, to support the purposes in subsection (b), subject to the safeguards in this section.

(d) Required system capabilities. The Program shall include, at minimum, capabilities to

(1) produce real time dashboards for claims flow, payment timeliness, denial rates, appeal rates, provider participation, and member access metrics,

(2) identify abnormal billing patterns and network level anomalies,

(3) estimate administrative cost and time burdens on providers and reduce such burdens through simplified rules, standardized documentation, and automation where appropriate, (3A) provider burden reduction accountability. The Secretary shall measure and publish, on not less than an annual basis, objective indicators of administrative burden on participating providers, including estimated hours spent on billing, documentation, prior authorization, and appeals, and shall publish year over year changes in such indicators and the specific rule or system changes responsible for reductions,

(4) monitor utilization and outcomes to identify low value or duplicative services and opportunities for prevention,

(5) measure the impact of payment policy changes on rural, frontier, and safety net access, and

(6) support program integrity actions under section 802 while minimizing improper denials and delays.

(e) Human review and due process. The Secretary shall ensure that

(1) any adverse action triggered by analytic or AI systems, including a payment hold, denial, recoupment, or referral for investigation, is subject to human review before final action, except for automated holds of limited duration for clearly defined high risk patterns as determined by regulation,

(2) providers and Plan members have access to a timely appeals process with clear explanations of the basis for the action, and

(3) the use of analytic tools does not create unreasonable barriers to medically necessary care.

(f) Transparency and reporting.

(1) Public reporting. Not later than 18 months after the main implementation date, and annually thereafter, the Secretary shall publish a performance report describing Plan performance on key metrics, including fraud recoveries, improper payment rates, administrative burden measures, access measures, and outcome measures.

(2) Model transparency. The Secretary shall publish plain language descriptions of the categories of signals and factors used by analytic systems for fraud detection and payment integrity, while protecting sensitive enforcement details.

(g) Model governance and audits.

(1) Governance. The Secretary shall establish model governance requirements, including documentation of training data sources, validation methods, change control, and ongoing monitoring for model drift.

(2) Independent audit. The Inspector General of the Department of Health and Human Services shall conduct periodic audits of the Program, including review of accuracy, error rates, improper denials, and compliance with subsection (e).

(3) Bias and fairness testing. The Secretary shall test analytic systems for disparate impacts on protected classes and on underserved communities, and shall mitigate identified issues through model adjustments and policy controls.

(h) Privacy and use limitations. Data and analytic outputs under this section shall be used only for health program administration, payment integrity, quality improvement, and public health functions authorized by this Act. Such data shall not be used for immigration enforcement or non health purposes.

(i) Cybersecurity. The Secretary shall implement cybersecurity controls consistent with Federal standards and shall conduct regular security testing of systems used under this section.

(j) Authorization of appropriations. There are authorized to be appropriated from the Trust Fund such sums as may be necessary to carry out this section, including procurement of analytic tooling, staffing, independent evaluation, and security measures.

TITLE IX. MEDICAL LIABILITY AND MALPRACTICE REFORM

SEC. 901. PURPOSE AND SCOPE.

(a) Purpose. The purpose of this title is to

(1) preserve meaningful remedies and full recovery of documented economic losses for patients who suffer injury as a result of substandard care,

(2) stabilize and reduce the cost of medical liability coverage for providers and facilities,

(3) reduce incentives for defensive medicine that does not improve outcomes, and

(4) align the medical liability system with the clinical standards and safety goals of the SAFECARE Plan in a way that improves patient safety over time.

(b) Scope. This title applies to any claim for personal injury or wrongful death that

(1) arises from the provision of, or failure to provide, health care services by a provider, and

(2) is paid in whole or in part, directly or indirectly, from the Trust Fund.

SEC. 902. SAFE HARBOR FOR ADHERENCE TO NATIONAL CLINICAL

STANDARDS.

(a) Presumption of reasonable care. In any action described in section 901, a provider shall be presumed to have met the applicable standard of care if the provider shows that

(1) the care at issue was delivered in accordance with clinical practice guidelines, coverage criteria, or quality standards that were issued or endorsed by the National Clinical Standards Board under this Act, and

(2) the provider documented in the medical record the basis for applying those guidelines, criteria, or standards to the patient at the time of treatment.

(b) Clinical judgment and justified deviation. A provider may depart from a guideline, criteria, or standard described in subsection (a) when, in the professional judgment of the provider, the specific clinical circumstances require a different course of action. If the provider documents in the medical record, at or near the time of care,

(1) the relevant guideline, criteria, or standard, and

(2) the clinical reasons for deviation in the case of that patient, then the presumption in subsection (a) shall apply in the same way as if the guideline had been followed.

(c) Rebuttal. The presumption under this section may be rebutted only by clear and convincing evidence that

(1) the provider materially misapplied a guideline, criteria, or standard, or

(2) the provider engaged in reckless, intentional, or grossly negligent conduct that no reasonable practitioner would have considered consistent with the protection of the patient.

(d) No immunity for gross negligence. Nothing in this section shall be construed to shield a provider from liability for conduct that constitutes reckless disregard of patient safety, intentional harm, fraud, or impairment due to substance abuse.

(e) Patient rights. The existence of guidelines, criteria, or standards under this Act shall not, by itself, limit a patient's right to file a claim or to recover economic damages for proven harm.

SEC. 903. LIMITATION ON NONECONOMIC DAMAGES.

(a) General rule. In any action described in section 901, the total amount of noneconomic damages that may be awarded to any claimant for all defendants combined shall not exceed

(1) 500,000 dollars for claims that do not involve catastrophic injury or death, and

(2) 1,000,000 dollars for claims that involve catastrophic injury or death, for claims arising in calendar years 2026 through 2030.

(b) Catastrophic injury. For purposes of this section, catastrophic injury means permanent and substantial impairment of a major bodily function. This includes but is not limited to permanent paralysis, severe traumatic brain injury with lasting functional loss, major loss of vision, or major loss of limb.

(c) Preservation of economic damages. This section does not limit recovery of economic damages. Economic damages include past and future medical expenses, rehabilitation costs, loss of earnings, loss of earning capacity, and the reasonable cost of necessary long term care and support.

(d) Indexing. Beginning in calendar year 2031, the Secretary shall adjust the dollar amounts in subsection (a) not less than once every three years. The adjustment shall be based on growth in a health care wage or cost index defined by regulation. The Secretary shall publish the updated amounts in the Federal Register.

(e) Exceptional cases. In an exceptional case in which the court finds, after written findings of fact, that

(1) the injury has resulted in extraordinary and lifelong loss of function, or

(2) the conduct of the defendant displayed reckless disregard of patient safety, the court may increase the applicable cap in subsection (a) by up to fifty percent for that claimant.

(f) Multiple claimants and wrongful death. In an action with multiple claimants or a wrongful death claim that arises from a single act or course of treatment, the court shall apportion the applicable cap among claimants as justice requires. The total noneconomic recovery for all claimants combined shall not exceed the applicable amount under subsection (a) as adjusted under subsection (d), except as increased under subsection (e).

(g) Limited preemption for Trust Fund paid claims.

(1) In general. For actions described in section 901 that are paid in whole or in part from the Trust Fund, State laws that allow higher noneconomic damages than the caps in this section shall not apply.

(2) State authority preserved. Except as provided in paragraph (1), States may apply additional patient protections, procedures, or lower caps, and may maintain or adopt health courts or panels, provided that such State provisions do not impose higher noneconomic damages than permitted under this section for Trust Fund paid claims.

SEC. 904. HEALTH COURTS AND SPECIALIZED PANELS.

(a) Encouragement of specialized forums. The Secretary, in consultation with the Attorney General, may provide grants and technical assistance to States that establish specialized health courts or expert panels to hear claims described in section 901.

(b) Features. A health court or panel supported under this section shall

(1) use judges or adjudicators with training or experience in health care law or policy,

(2) make use of neutral medical experts to assist in evaluating standard of care and causation,

(3) issue written decisions that summarize the evidence and reasoning, and

(4) collect and share de identified data on adverse events and rulings to support patient safety efforts.

SEC. 905. MALPRACTICE INSURANCE RATE REVIEW.

The Secretary may coordinate with State insurance regulators to review malpractice insurance rates for reasonableness, taking into account the liability reforms in this title and data on claims, and may issue reports on trends in premiums and access to coverage in high risk specialties and regions.

SEC. 906. REPORTING AND PATIENT SAFETY INTEGRATION.

The Secretary shall promote integration of malpractice claims data with patient safety efforts by

(1) supporting confidential reporting systems for near misses and adverse events, and

(2) encouraging the use of claims analysis to identify patterns, system failures, and opportunities for prevention, without turning every report into a punishment event for individual clinicians acting in good faith.

SEC. 907. PRESERVATION OF STATE PROCEDURES.

Except as expressly provided in this title, nothing in this title shall be construed to

(1) alter State rules on pleading, discovery, or trial procedure, or

(2) limit the authority of State medical boards to license, discipline, or remove providers.

TITLE X. TRANSITION AND INTEGRATION OF EXISTING PROGRAMS

SEC. 1001. INTEGRATION OF MEDICARE, MEDICAID, CHIP, AND ACA

SUBSIDIES.

(a) Phased integration. Over the transition period defined in section 1005, the essential health coverage components of Medicare, Medicaid, the Children's Health Insurance Program, and premium subsidies and cost sharing reductions under the Affordable Care Act shall be integrated into the Plan.

(b) Protection of beneficiaries. During transition, no individual shall lose coverage or see gaps in treatment solely because of integration activities.

SEC. 1002. VETERANS HEALTH CARE.

(a) Core coverage. Essential health services for veterans shall be covered under the Plan in the same way as for other Plan members.

(b) Supplemental veterans benefits. The Department of Veterans Affairs may continue to operate programs that provide supplemental benefits and specialized services beyond the national essential benefit floor.

SEC. 1003. FEDERAL EMPLOYEE AND OTHER FEDERAL HEALTH PROGRAMS.

Federal employee health benefits and other Federal health programs shall be aligned with the Plan according to a schedule set by the Office of Personnel Management and the Secretary. Basic essential coverage shall be provided through the Plan. Supplemental benefits may remain separate.

SEC. 1004. PRIVATE COVERAGE TRANSITION RULES.

(a) Sunset of duplicative plans. During the transition period, private health plans that provide duplicative basic coverage shall be phased out or converted to supplemental plans that comply with section 105.

(b) Continuity of treatment. The Secretary shall adopt rules so that individuals who are in the middle of treatment at the time of transition can continue that treatment without interruption.

SEC. 1005. PHASED IMPLEMENTATION SCHEDULE.

(a) Planning and initial enrollment. The planning period shall begin on the date of enactment. The Secretary shall complete key regulations, data systems, and enrollment mechanisms within twenty four months.

(b) Year three after enactment. On January 1 of the third calendar year after enactment

(1) automatic enrollment of legal residents shall begin, subject to readiness certification under section 303A,

(2) individuals covered by major Federal programs and uninsured individuals shall be brought into the Plan, and

(3) new employer and employee contributions shall take effect.

(c) Years three through six. From year three through year six after enactment

(1) employer sponsored coverage shall be folded into the Plan as existing contracts expire,

(2) duplicative public payments to private plans shall be reduced, and

(3) tuition caps, education support payments, scholarships, and loan relief programs shall be fully launched.

(d) Years seven through ten. From year seven through year ten

(1) integration of remaining Federal programs shall be completed,

(2) payment rules and benefits shall be adjusted based on observed data, and

(3) fraud detection and enforcement shall be strengthened as the data platform matures.

TITLE XI. GENERAL PROVISIONS

SEC. 1101. REGULATIONS.

The Secretary and the Secretary of the Treasury shall issue such regulations as are necessary or appropriate to carry out this Act.

SEC. 1102. SEVERABILITY.

If any provision of this Act, or the application of such provision to any person or circumstance, is held invalid, the remainder of this Act, and the application of the other provisions to any person or circumstance, shall not be affected.

SEC. 1103. EFFECTIVE DATES.

(a) General rule. Except as provided in subsection (b), this Act shall take effect on the date of enactment.

(b) Main implementation date. The main implementation date for Plan operations, for purposes of employer and employee contributions and coverage obligations, shall be January 1 of the third calendar year that begins after the date of enactment.

(c) Payroll tax replacement. On and after the main implementation date, the replacement of the Hospital Insurance payroll tax described in section 205 shall apply.