

111TH CONGRESS
1ST SESSION

H. R. 676

To provide for comprehensive health insurance coverage for all United States residents, improved health care delivery, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 26, 2009

Mr. CONYERS (for himself, Mr. KUCINICH, Ms. WATSON, Mr. ELLISON, Mr. HINCHEY, Mr. DAVIS of Illinois, Ms. BALDWIN, Ms. LEE of California, Mr. MASSA, Mr. NADLER of New York, Mr. McDERMOTT, Mr. DOYLE, Mr. GUTIERREZ, Mr. OLVER, Ms. KAPTUR, Ms. JACKSON-LEE of Texas, Mr. ENGEL, Mr. MEEKS of New York, Ms. CLARKE, Mr. FARR, Mrs. NAPOLITANO, Ms. PINGREE of Maine, Mr. TONKO, Ms. EDWARDS of Maryland, Mr. GRIJALVA, Mr. BERMAN, Mr. DELAHUNT, Mr. CLAY, Ms. KILPATRICK of Michigan, Ms. WOOLSEY, and Mr. COHEN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for comprehensive health insurance coverage for all United States residents, improved health care delivery, and for other purposes.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the
 3 “United States National Health Care Act or the Ex-
 4 panded and Improved Medicare for All Act”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Definitions and terms.

TITLE I—ELIGIBILITY AND BENEFITS

- Sec. 101. Eligibility and registration.
- Sec. 102. Benefits and portability.
- Sec. 103. Qualification of participating providers.
- Sec. 104. Prohibition against duplicating coverage.

TITLE II—FINANCES

Subtitle A—Budgeting and Payments

- Sec. 201. Budgeting process.
- Sec. 202. Payment of providers and health care clinicians.
- Sec. 203. Payment for long-term care.
- Sec. 204. Mental health services.
- Sec. 205. Payment for prescription medications, medical supplies, and medically necessary assistive equipment.
- Sec. 206. Consultation in establishing reimbursement levels.

Subtitle B—Funding

- Sec. 211. Overview: funding the USNHC Program.
- Sec. 212. Appropriations for existing programs.

TITLE III—ADMINISTRATION

- Sec. 301. Public administration; appointment of Director.
- Sec. 302. Office of Quality Control.
- Sec. 303. Regional and State administration; employment of displaced clerical workers.
- Sec. 304. Confidential Electronic Patient Record System.
- Sec. 305. National Board of Universal Quality and Access.

TITLE IV—ADDITIONAL PROVISIONS

- Sec. 401. Treatment of VA and IHS health programs.
- Sec. 402. Public health and prevention.
- Sec. 403. Reduction in health disparities.

TITLE V—EFFECTIVE DATE

- Sec. 501. Effective date.

1 **SEC. 2. DEFINITIONS AND TERMS.**

2 In this Act:

3 (1) USNHC PROGRAM; PROGRAM.—The terms
4 “USNHC Program” and “Program” mean the pro-
5 gram of benefits provided under this Act and, unless
6 the context otherwise requires, the Secretary with
7 respect to functions relating to carrying out such
8 program.

9 (2) NATIONAL BOARD OF UNIVERSAL QUALITY
10 AND ACCESS.—The term “National Board of Uni-
11 versal Quality and Access” means such Board estab-
12 lished under section 305.

13 (3) REGIONAL OFFICE.—The term “regional of-
14 fice” means a regional office established under sec-
15 tion 303.

16 (4) SECRETARY.—The term “Secretary” means
17 the Secretary of Health and Human Services.

18 (5) DIRECTOR.—The term “Director” means,
19 in relation to the Program, the Director appointed
20 under section 301.

21 **TITLE I—ELIGIBILITY AND**
22 **BENEFITS**

23 **SEC. 101. ELIGIBILITY AND REGISTRATION.**

24 (a) IN GENERAL.—All individuals residing in the
25 United States (including any territory of the United
26 States) are covered under the USNHC Program entitling

1 them to a universal, best quality standard of care. Each
2 such individual shall receive a card with a unique number
3 in the mail. An individual's social security number shall
4 not be used for purposes of registration under this section.

5 (b) REGISTRATION.—Individuals and families shall
6 receive a United States National Health Insurance Card
7 in the mail, after filling out a United States National
8 Health Insurance application form at a health care pro-
9 vider. Such application form shall be no more than 2 pages
10 long.

11 (c) PRESUMPTION.—Individuals who present them-
12 selves for covered services from a participating provider
13 shall be presumed to be eligible for benefits under this Act,
14 but shall complete an application for benefits in order to
15 receive a United States National Health Insurance Card
16 and have payment made for such benefits.

17 (d) RESIDENCY CRITERIA.—The Secretary shall pro-
18 mulgate a rule that provides criteria for determining resi-
19 dency for eligibility purposes under the USNHC Program.

20 (e) COVERAGE FOR VISITORS.—The Secretary shall
21 promulgate a rule regarding visitors from other countries
22 who seek premeditated non-emergency surgical proce-
23 dures. Such a rule should facilitate the establishment of
24 country-to-country reimbursement arrangements or self

1 pay arrangements between the visitor and the provider of
2 care.

3 **SEC. 102. BENEFITS AND PORTABILITY.**

4 (a) IN GENERAL.—The health care benefits under
5 this Act cover all medically necessary services, including
6 at least the following:

- 7 (1) Primary care and prevention.
- 8 (2) Inpatient care.
- 9 (3) Outpatient care.
- 10 (4) Emergency care.
- 11 (5) Prescription drugs.
- 12 (6) Durable medical equipment.
- 13 (7) Long-term care.
- 14 (8) Palliative care.
- 15 (9) Mental health services.
- 16 (10) The full scope of dental services (other
17 than cosmetic dentistry).
- 18 (11) Substance abuse treatment services.
- 19 (12) Chiropractic services.
- 20 (13) Basic vision care and vision correction
21 (other than laser vision correction for cosmetic pur-
22 poses).
- 23 (14) Hearing services, including coverage of
24 hearing aids.
- 25 (15) Podiatric care.

1 (b) PORTABILITY.—Such benefits are available
2 through any licensed health care clinician anywhere in the
3 United States that is legally qualified to provide the bene-
4 fits.

5 (c) NO COST-SHARING.—No deductibles, copay-
6 ments, coinsurance, or other cost-sharing shall be imposed
7 with respect to covered benefits.

8 **SEC. 103. QUALIFICATION OF PARTICIPATING PROVIDERS.**

9 (a) REQUIREMENT TO BE PUBLIC OR NON-PROF-
10 IT.—

11 (1) IN GENERAL.—No institution may be a par-
12 ticipating provider unless it is a public or not-for-
13 profit institution. Private physicians, private clinics,
14 and private health care providers shall continue to
15 operate as private entities, but are prohibited from
16 being investor owned.

17 (2) CONVERSION OF INVESTOR-OWNED PRO-
18 VIDERS.—For-profit providers of care opting to par-
19 ticipate shall be required to convert to not-for-profit
20 status.

21 (3) PRIVATE DELIVERY OF CARE REQUIRE-
22 MENT.—For-profit providers of care that convert to
23 non-profit status shall remain privately owned and
24 operated entities.

1 (4) COMPENSATION FOR CONVERSION.—The
2 owners of such for-profit providers shall be com-
3 pensated for reasonable financial losses incurred as
4 a result of the conversion from for-profit to non-
5 profit status.

6 (5) FUNDING.—There are authorized to be ap-
7 propriated from the Treasury such sums as are nec-
8 essary to compensate investor-owned providers as
9 provided for under paragraph (3).

10 (6) REQUIREMENTS.—The payments to owners
11 of converting for-profit providers shall occur during
12 a 15-year period, through the sale of U.S. Treasury
13 Bonds. Payment for conversions under paragraph
14 (3) shall not be made for loss of business profits.

15 (7) MECHANISM FOR CONVERSION PROCESS.—
16 The Secretary shall promulgate a rule to provide a
17 mechanism to further the timely, efficient, and fea-
18 sible conversion of for-profit providers of care.

19 (b) QUALITY STANDARDS.—

20 (1) IN GENERAL.—Health care delivery facili-
21 ties must meet State quality and licensing guidelines
22 as a condition of participation under such program,
23 including guidelines regarding safe staffing and
24 quality of care.

1 (2) LICENSURE REQUIREMENTS.—Participating
2 clinicians must be licensed in their State of practice
3 and meet the quality standards for their area of
4 care. No clinician whose license is under suspension
5 or who is under disciplinary action in any State may
6 be a participating provider.

7 (c) PARTICIPATION OF HEALTH MAINTENANCE OR-
8 GANIZATIONS.—

9 (1) IN GENERAL.—Non-profit health mainte-
10 nance organizations that deliver care in their own
11 facilities and employ clinicians on a salaried basis
12 may participate in the program and receive global
13 budgets or capitation payments as specified in sec-
14 tion 202.

15 (2) EXCLUSION OF CERTAIN HEALTH MAINTEN-
16 NANCE ORGANIZATIONS.—Other health maintenance
17 organizations, including those which principally con-
18 tract to pay for services delivered by non-employees,
19 shall be classified as insurance plans. Such organiza-
20 tions shall not be participating providers, and are
21 subject to the regulations promulgated by reason of
22 section 104(a) (relating to prohibition against dupli-
23 cating coverage).

1 (d) FREEDOM OF CHOICE.—Patients shall have free
2 choice of participating physicians and other clinicians,
3 hospitals, and inpatient care facilities.

4 **SEC. 104. PROHIBITION AGAINST DUPLICATING COVERAGE.**

5 (a) IN GENERAL.—It is unlawful for a private health
6 insurer to sell health insurance coverage that duplicates
7 the benefits provided under this Act.

8 (b) CONSTRUCTION.—Nothing in this Act shall be
9 construed as prohibiting the sale of health insurance cov-
10 erage for any additional benefits not covered by this Act,
11 such as for cosmetic surgery or other services and items
12 that are not medically necessary.

13 **TITLE II—FINANCES**

14 **Subtitle A—Budgeting and**
15 **Payments**

16 **SEC. 201. BUDGETING PROCESS.**

17 (a) ESTABLISHMENT OF OPERATING BUDGET AND
18 CAPITAL EXPENDITURES BUDGET.—

19 (1) IN GENERAL.—To carry out this Act there
20 are established on an annual basis consistent with
21 this title—

22 (A) an operating budget, including
23 amounts for optimal physician, nurse, and other
24 health care professional staffing;

25 (B) a capital expenditures budget;

1 (C) reimbursement levels for providers con-
2 sistent with subtitle B; and

3 (D) a health professional education budget,
4 including amounts for the continued funding of
5 resident physician training programs.

6 (2) REGIONAL ALLOCATION.—After Congress
7 appropriates amounts for the annual budget for the
8 USNHC Program, the Director shall provide the re-
9 gional offices with an annual funding allotment to
10 cover the costs of each region’s expenditures. Such
11 allotment shall cover global budgets, reimbursements
12 to clinicians, health professional education, and cap-
13 ital expenditures. Regional offices may receive addi-
14 tional funds from the national program at the dis-
15 cretion of the Director.

16 (b) OPERATING BUDGET.—The operating budget
17 shall be used for—

18 (1) payment for services rendered by physicians
19 and other clinicians;

20 (2) global budgets for institutional providers;

21 (3) capitation payments for capitated groups;

22 and

23 (4) administration of the Program.

24 (c) CAPITAL EXPENDITURES BUDGET.—The capital
25 expenditures budget shall be used for funds needed for—

1 (1) the construction or renovation of health fa-
2 cilities; and

3 (2) for major equipment purchases.

4 (d) PROHIBITION AGAINST CO-MINGLING OPER-
5 ATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is pro-
6 hibited to use funds under this Act that are earmarked—

7 (1) for operations for capital expenditures; or

8 (2) for capital expenditures for operations.

9 **SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLI-**
10 **NICIANS.**

11 (a) ESTABLISHING GLOBAL BUDGETS; MONTHLY
12 LUMP SUM.—

13 (1) IN GENERAL.—The USNHC Program,
14 through its regional offices, shall pay each institu-
15 tional provider of care, including hospitals, nursing
16 homes, community or migrant health centers, home
17 care agencies, or other institutional providers or pre-
18 paid group practices, a monthly lump sum to cover
19 all operating expenses under a global budget.

20 (2) ESTABLISHMENT OF GLOBAL BUDGETS.—

21 The global budget of a provider shall be set through
22 negotiations between providers, State directors, and
23 regional directors, but are subject to the approval of
24 the Director. The budget shall be negotiated annu-
25 ally, based on past expenditures, projected changes

1 in levels of services, wages and input, costs, a pro-
2 vider's maximum capacity to provide care, and pro-
3 posed new and innovative programs.

4 (b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND
5 CERTAIN OTHER HEALTH PROFESSIONALS.—

6 (1) IN GENERAL.—The Program shall pay phy-
7 sicians, dentists, doctors of osteopathy, pharmacists,
8 psychologists, chiropractors, doctors of optometry,
9 nurse practitioners, nurse midwives, physicians' as-
10 sistants, and other advanced practice clinicians as li-
11 censed and regulated by the States by the following
12 payment methods:

13 (A) Fee for service payment under para-
14 graph (2).

15 (B) Salaried positions in institutions re-
16 ceiving global budgets under paragraph (3).

17 (C) Salaried positions within group prac-
18 tices or non-profit health maintenance organiza-
19 tions receiving capitation payments under para-
20 graph (4).

21 (2) FEE FOR SERVICE.—

22 (A) IN GENERAL.—The Program shall ne-
23 gotiate a simplified fee schedule that is fair and
24 optimal with representatives of physicians and
25 other clinicians, after close consultation with

1 the National Board of Universal Quality and
2 Access and regional and State directors. Ini-
3 tially, the current prevailing fees or reimburse-
4 ment would be the basis for the fee negotiation
5 for all professional services covered under this
6 Act.

7 (B) CONSIDERATIONS.—In establishing
8 such schedule, the Director shall take into con-
9 sideration the following:

10 (i) The need for a uniform national
11 standard.

12 (ii) The goal of ensuring that physi-
13 cians, clinicians, pharmacists, and other
14 medical professionals be compensated at a
15 rate which reflects their expertise and the
16 value of their services, regardless of geo-
17 graphic region and past fee schedules.

18 (C) STATE PHYSICIAN PRACTICE REVIEW
19 BOARDS.—The State director for each State, in
20 consultation with representatives of the physi-
21 cian community of that State, shall establish
22 and appoint a physician practice review board
23 to assure quality, cost effectiveness, and fair re-
24 imbursements for physician delivered services.

1 (D) FINAL GUIDELINES.—The Director
2 shall be responsible for promulgating final
3 guidelines to all providers.

4 (E) BILLING.—Under this Act physicians
5 shall submit bills to the regional director on a
6 simple form, or via computer. Interest shall be
7 paid to providers who are not reimbursed within
8 30 days of submission.

9 (F) NO BALANCE BILLING.—Licensed
10 health care clinicians who accept any payment
11 from the USNHC Program may not bill any
12 patient for any covered service.

13 (G) UNIFORM COMPUTER ELECTRONIC
14 BILLING SYSTEM.—The Director shall create a
15 uniform computerized electronic billing system,
16 including those areas of the United States
17 where electronic billing is not yet established.

18 (3) SALARIES WITHIN INSTITUTIONS RECEIVING
19 GLOBAL BUDGETS.—

20 (A) IN GENERAL.—In the case of an insti-
21 tution, such as a hospital, health center, group
22 practice, community and migrant health center,
23 or a home care agency that elects to be paid a
24 monthly global budget for the delivery of health
25 care as well as for education and prevention

1 programs, physicians and other clinicians em-
2 ployed by such institutions shall be reimbursed
3 through a salary included as part of such a
4 budget.

5 (B) SALARY RANGES.—Salary ranges for
6 health care providers shall be determined in the
7 same way as fee schedules under paragraph (2).

8 (4) SALARIES WITHIN CAPITATED GROUPS.—

9 (A) IN GENERAL.—Health maintenance or-
10 ganizations, group practices, and other institu-
11 tions may elect to be paid capitation payments
12 to cover all outpatient, physician, and medical
13 home care provided to individuals enrolled to
14 receive benefits through the organization or en-
15 tity.

16 (B) SCOPE.—Such capitation may include
17 the costs of services of licensed physicians and
18 other licensed, independent practitioners pro-
19 vided to inpatients. Other costs of inpatient and
20 institutional care shall be excluded from capita-
21 tion payments, and shall be covered under insti-
22 tutions' global budgets.

23 (C) PROHIBITION OF SELECTIVE ENROLL-
24 MENT.—Patients shall be permitted to enroll or
25 disenroll from such organizations or entities

1 without discrimination and with appropriate no-
2 tice.

3 (D) HEALTH MAINTENANCE ORGANIZA-
4 TIONS.—Under this Act—

5 (i) health maintenance organizations
6 shall be required to reimburse physicians
7 based on a salary; and

8 (ii) financial incentives between such
9 organizations and physicians based on uti-
10 lization are prohibited.

11 **SEC. 203. PAYMENT FOR LONG-TERM CARE.**

12 (a) ALLOTMENT FOR REGIONS.—The Program shall
13 provide for each region a single budgetary allotment to
14 cover a full array of long-term care services under this
15 Act.

16 (b) REGIONAL BUDGETS.—Each region shall provide
17 a global budget to local long-term care providers for the
18 full range of needed services, including in-home, nursing
19 home, and community based care.

20 (c) BASIS FOR BUDGETS.—Budgets for long-term
21 care services under this section shall be based on past ex-
22 penditures, financial and clinical performance, utilization,
23 and projected changes in service, wages, and other related
24 factors.

1 (d) FAVORING NON-INSTITUTIONAL CARE.—All ef-
2 forts shall be made under this Act to provide long-term
3 care in a home- or community-based setting, as opposed
4 to institutional care.

5 **SEC. 204. MENTAL HEALTH SERVICES.**

6 (a) IN GENERAL.—The Program shall provide cov-
7 erage for all medically necessary mental health care on
8 the same basis as the coverage for other conditions. Li-
9 censed mental health clinicians shall be paid in the same
10 manner as specified for other health professionals, as pro-
11 vided for in section 202(b).

12 (b) FAVORING COMMUNITY-BASED CARE.—The
13 USNHC Program shall cover supportive residences, occu-
14 pational therapy, and ongoing mental health and coun-
15 seling services outside the hospital for patients with seri-
16 ous mental illness. In all cases the highest quality and
17 most effective care shall be delivered, and, for some indi-
18 viduals, this may mean institutional care.

19 **SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS,**
20 **MEDICAL SUPPLIES, AND MEDICALLY NEC-**
21 **CESSARY ASSISTIVE EQUIPMENT.**

22 (a) NEGOTIATED PRICES.—The prices to be paid
23 each year under this Act for covered pharmaceuticals,
24 medical supplies, and medically necessary assistive equip-
25 ment shall be negotiated annually by the Program.

1 (b) PRESCRIPTION DRUG FORMULARY.—

2 (1) IN GENERAL.—The Program shall establish
3 a prescription drug formulary system, which shall
4 encourage best-practices in prescribing and discour-
5 age the use of ineffective, dangerous, or excessively
6 costly medications when better alternatives are avail-
7 able.

8 (2) PROMOTION OF USE OF GENERICS.—The
9 formulary shall promote the use of generic medica-
10 tions but allow the use of brand-name and off-for-
11 mulary medications.

12 (3) FORMULARY UPDATES AND PETITION
13 RIGHTS.—The formulary shall be updated frequently
14 and clinicians and patients may petition their region
15 or the Director to add new pharmaceuticals or to re-
16 move ineffective or dangerous medications from the
17 formulary.

18 **SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSE-**
19 **MENT LEVELS.**

20 Reimbursement levels under this subtitle shall be set
21 after close consultation with regional and State Directors
22 and after the annual meeting of National Board of Uni-
23 versal Quality and Access.

Subtitle B—Funding

SEC. 211. OVERVIEW: FUNDING THE USNHC PROGRAM.

(a) IN GENERAL.—The USNHC Program is to be funded as provided in subsection (c)(1).

(b) USNHC TRUST FUND.—There shall be established a USNHC Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) FUNDING.—

(1) IN GENERAL.—There are appropriated to the USNHC Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) Increasing personal income taxes on the top 5 percent income earners.

(C) Instituting a modest and progressive excise tax on payroll and self-employment income.

(D) Instituting a small tax on stock and bond transactions.

(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING.—Funding otherwise required for the Program is reduced as a result of—

(A) vastly reducing paperwork;

1 (B) requiring a rational bulk procurement
2 of medications under section 205(a); and

3 (C) improved access to preventive health
4 care.

5 (3) ADDITIONAL ANNUAL APPROPRIATIONS TO
6 USNHC PROGRAM.—Additional sums are authorized
7 to be appropriated annually as needed to maintain
8 maximum quality, efficiency, and access under the
9 Program.

10 **SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS.**

11 Notwithstanding any other provision of law, there are
12 hereby transferred and appropriated to carry out this Act,
13 amounts from the Treasury equivalent to the amounts the
14 Secretary estimates would have been appropriated and ex-
15 pended for Federal public health care programs, including
16 funds that would have been appropriated under the Medi-
17 care program under title XVIII of the Social Security Act,
18 under the Medicaid program under title XIX of such Act,
19 and under the Children’s Health Insurance Program
20 under title XXI of such Act.

1 **TITLE III—ADMINISTRATION**

2 **SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DI-**
3 **RECTOR.**

4 (a) IN GENERAL.—Except as otherwise specifically
5 provided, this Act shall be administered by the Secretary
6 through a Director appointed by the Secretary.

7 (b) LONG-TERM CARE.—The Director shall appoint
8 a director for long-term care who shall be responsible for
9 administration of this Act and ensuring the availability
10 and accessibility of high quality long-term care services.

11 (c) MENTAL HEALTH.—The Director shall appoint a
12 director for mental health who shall be responsible for ad-
13 ministration of this Act and ensuring the availability and
14 accessibility of high quality mental health services.

15 **SEC. 302. OFFICE OF QUALITY CONTROL.**

16 The Director shall appoint a director for an Office
17 of Quality Control. Such director shall, after consultation
18 with state and regional directors, provide annual rec-
19 ommendations to Congress, the President, the Secretary,
20 and other Program officials on how to ensure the highest
21 quality health care service delivery. The director of the Of-
22 fice of Quality Control shall conduct an annual review on
23 the adequacy of medically necessary services, and shall
24 make recommendations of any proposed changes to the

1 Congress, the President, the Secretary, and other USNHC
2 Program officials.

3 **SEC. 303. REGIONAL AND STATE ADMINISTRATION; EM-**
4 **PLOYMENT OF DISPLACED CLERICAL WORK-**
5 **ERS.**

6 (a) ESTABLISHMENT OF USNHC PROGRAM RE-
7 GIONAL OFFICES.—The Secretary shall establish and
8 maintain USNHC regional offices for the purpose of dis-
9 tributing funds to providers of care. Whenever possible,
10 the Secretary should incorporate pre-existing Medicare in-
11 frastructure for this purpose.

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

14 (1) one regional director appointed by the Di-
15 rector; and

16 (2) for each State in the region, a deputy direc-
17 tor (in this Act referred to as a “State Director”)
18 appointed by the governor of that State.

19 (c) REGIONAL OFFICE DUTIES.—Regional offices of
20 the Program shall be responsible for—

21 (1) coordinating funding to health care pro-
22 viders and physicians; and

23 (2) coordinating billing and reimbursements
24 with physicians and health care providers through a
25 State-based reimbursement system.

1 (d) STATE DIRECTOR'S DUTIES.—Each State Direc-
2 tor shall be responsible for the following duties:

3 (1) Providing an annual state health care needs
4 assessment report to the National Board of Uni-
5 versal Quality and Access, and the regional board,
6 after a thorough examination of health needs, in
7 consultation with public health officials, clinicians,
8 patients, and patient advocates.

9 (2) Health planning, including oversight of the
10 placement of new hospitals, clinics, and other health
11 care delivery facilities.

12 (3) Health planning, including oversight of the
13 purchase and placement of new health equipment to
14 ensure timely access to care and to avoid duplica-
15 tion.

16 (4) Submitting global budgets to the regional
17 director.

18 (5) Recommending changes in provider reim-
19 bursement or payment for delivery of health services
20 in the State.

21 (6) Establishing a quality assurance mechanism
22 in the State in order to minimize both under utiliza-
23 tion and over utilization and to assure that all pro-
24 viders meet high quality standards.

1 (7) Reviewing program disbursements on a
2 quarterly basis and recommending needed adjust-
3 ments in fee schedules needed to achieve budgetary
4 targets and assure adequate access to needed care.

5 (e) FIRST PRIORITY IN RETRAINING AND JOB
6 PLACEMENT; 2 YEARS OF SALARY PARITY BENEFITS.—
7 The Program shall provide that clerical, administrative,
8 and billing personnel in insurance companies, doctors of-
9 fices, hospitals, nursing facilities, and other facilities
10 whose jobs are eliminated due to reduced administration—

11 (1) should have first priority in retraining and
12 job placement in the new system; and

13 (2) shall be eligible to receive two years of
14 USNHC employment transition benefits with each
15 year's benefit equal to salary earned during the last
16 12 months of employment, but shall not exceed
17 \$100,000 per year.

18 (f) ESTABLISHMENT OF USNHC EMPLOYMENT
19 TRANSITION FUND.—The Secretary shall establish a trust
20 fund from which expenditures shall be made to recipients
21 of the benefits allocated in subsection (e).

22 (g) ANNUAL APPROPRIATIONS TO USNHC EMPLOY-
23 MENT TRANSITION FUND.—Sums are authorized to be ap-
24 propriated annually as needed to fund the USNHC Em-
25 ployment Transition Benefits.

1 (h) RETENTION OF RIGHT TO UNEMPLOYMENT BEN-
2 EFITS.—Nothing in this section shall be interpreted as a
3 waiver of USNHC Employment Transition benefit recipi-
4 ents’ right to receive Federal and State unemployment
5 benefits.

6 **SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD**
7 **SYSTEM.**

8 (a) IN GENERAL.—The Secretary shall create a
9 standardized, confidential electronic patient record system
10 in accordance with laws and regulations to maintain accu-
11 rate patient records and to simplify the billing process,
12 thereby reducing medical errors and bureaucracy.

13 (b) PATIENT OPTION.—Notwithstanding that all bill-
14 ing shall be preformed electronically, patients shall have
15 the option of keeping any portion of their medical records
16 separate from their electronic medical record.

17 **SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND**
18 **ACCESS.**

19 (a) ESTABLISHMENT.—

20 (1) IN GENERAL.—There is established a Na-
21 tional Board of Universal Quality and Access (in
22 this section referred to as the “Board”) consisting
23 of 15 members appointed by the President, by and
24 with the advice and consent of the Senate.

1 (2) QUALIFICATIONS.—The appointed members
2 of the Board shall include at least one of each of the
3 following:

4 (A) Health care professionals.

5 (B) Representatives of institutional pro-
6 viders of health care.

7 (C) Representatives of health care advo-
8 cacy groups.

9 (D) Representatives of labor unions.

10 (E) Citizen patient advocates.

11 (3) TERMS.—Each member shall be appointed
12 for a term of 6 years, except that the President shall
13 stagger the terms of members initially appointed so
14 that the term of no more than 3 members expires
15 in any year.

16 (4) PROHIBITION ON CONFLICTS OF INTER-
17 EST.—No member of the Board shall have a finan-
18 cial conflict of interest with the duties before the
19 Board.

20 (b) DUTIES.—

21 (1) IN GENERAL.—The Board shall meet at
22 least twice per year and shall advise the Secretary
23 and the Director on a regular basis to ensure qual-
24 ity, access, and affordability.

1 (2) SPECIFIC ISSUES.—The Board shall specifi-
2 cally address the following issues:

3 (A) Access to care.

4 (B) Quality improvement.

5 (C) Efficiency of administration.

6 (D) Adequacy of budget and funding.

7 (E) Appropriateness of reimbursement lev-
8 els of physicians and other providers.

9 (F) Capital expenditure needs.

10 (G) Long-term care.

11 (H) Mental health and substance abuse
12 services.

13 (I) Staffing levels and working conditions
14 in health care delivery facilities.

15 (3) ESTABLISHMENT OF UNIVERSAL, BEST
16 QUALITY STANDARD OF CARE.—The Board shall
17 specifically establish a universal, best quality of
18 standard of care with respect to—

19 (A) appropriate staffing levels;

20 (B) appropriate medical technology;

21 (C) design and scope of work in the health
22 workplace;

23 (D) best practices; and

1 (E) salary level and working conditions of
2 physicians, clinicians, nurses, other medical pro-
3 fessionals, and appropriate support staff.

4 (4) TWICE-A-YEAR REPORT.—The Board shall
5 report its recommendations twice each year to the
6 Secretary, the Director, Congress, and the Presi-
7 dent.

8 (c) COMPENSATION, ETC.—The following provisions
9 of section 1805 of the Social Security Act shall apply to
10 the Board in the same manner as they apply to the Medi-
11 care Payment Assessment Commission (except that any
12 reference to the Commission or the Comptroller General
13 shall be treated as references to the Board and the Sec-
14 retary, respectively):

15 (1) Subsection (c)(4) (relating to compensation
16 of Board members).

17 (2) Subsection (c)(5) (relating to chairman and
18 vice chairman).

19 (3) Subsection (c)(6) (relating to meetings).

20 (4) Subsection (d) (relating to director and
21 staff; experts and consultants).

22 (5) Subsection (e) (relating to powers).

1 **TITLE IV—ADDITIONAL**
2 **PROVISIONS**

3 **SEC. 401. TREATMENT OF VA AND IHS HEALTH PROGRAMS.**

4 (a) VA HEALTH PROGRAMS.—This Act provides for
5 health programs of the Department of Veterans' Affairs
6 to initially remain independent for the 10-year period that
7 begins on the date of the establishment of the USNHC
8 Program. After such 10-year period, the Congress shall
9 reevaluate whether such programs shall remain inde-
10 pendent or be integrated into the USNHC Program.

11 (b) INDIAN HEALTH SERVICE PROGRAMS.—This Act
12 provides for health programs of the Indian Health Service
13 to initially remain independent for the 5-year period that
14 begins on the date of the establishment of the USNHC
15 Program, after which such programs shall be integrated
16 into the USNHC Program.

17 **SEC. 402. PUBLIC HEALTH AND PREVENTION.**

18 It is the intent of this Act that the Program at all
19 times stress the importance of good public health through
20 the prevention of diseases.

21 **SEC. 403. REDUCTION IN HEALTH DISPARITIES.**

22 It is the intent of this Act to reduce health disparities
23 by race, ethnicity, income and geographic region, and to
24 provide high quality, cost-effective, culturally appropriate

1 care to all individuals regardless of race, ethnicity, sexual
2 orientation, or language.

3 **TITLE V—EFFECTIVE DATE**

4 **SEC. 501. EFFECTIVE DATE.**

5 Except as otherwise specifically provided, this Act
6 shall take effect on the first day of the first year that be-
7 gins more than 1 year after the date of the enactment
8 of this Act, and shall apply to items and services furnished
9 on or after such date.

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