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AMENDMENT TO THE AMENDMENT IN THE  
NATURE OF A SUBSTITUTE FOR H.R. 3200  
OFFERED BY MR. WEINER OF NEW YORK AND  
MR. WELCH OF VERMONT

{AINS-EC\_001}

Amend division A to read as follows:

1 **DIVISION A—UNITED STATES**  
2 **NATIONAL HEALTH CARE**

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

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

7 (b) **TABLE OF CONTENTS.**—The table of contents of  
8 this division is as follows:

DIVISION A—UNITED STATES NATIONAL HEALTH CARE

- 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. Public health and prevention.

Sec. 402. Reduction in health disparities.

TITLE V—EFFECTIVE DATE

Sec. 501. Effective date.

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

2 In this division:

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

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

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

6           (5) DIRECTOR.—The term “Director” means,  
7           in relation to the Program, the Director appointed  
8           under section 301.

## 9           **TITLE I—ELIGIBILITY AND** 10           **BENEFITS**

### 11       **SEC. 101. ELIGIBILITY AND REGISTRATION.**

12       (a) IN GENERAL.—All individuals residing in the  
13       United States (including any territory of the United  
14       States) are covered under the USNHC Program entitling  
15       them to a universal, best quality standard of care. Each  
16       such individual shall receive a card with a unique number  
17       in the mail. An individual’s social security number shall  
18       not be used for purposes of registration under this section.

19       (b) REGISTRATION.—Individuals and families shall  
20       receive a United States National Health Insurance Card  
21       in the mail, after filling out a United States National  
22       Health Insurance application form at a health care pro-  
23       vider. Such application form shall be no more than 2 pages  
24       long.

1           (c) PRESUMPTION.—Individuals who present them-  
2 selves for covered services from a participating provider  
3 shall be presumed to be eligible for benefits under this di-  
4 vision, but shall complete an application for benefits in  
5 order to receive a United States National Health Insur-  
6 ance Card and have payment made for such benefits.

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

10          (e) COVERAGE FOR VISITORS.—The Secretary shall  
11 promulgate a rule regarding visitors from other countries  
12 who seek premeditated non-emergency surgical proce-  
13 dures. Such a rule should facilitate the establishment of  
14 country-to-country reimbursement arrangements or self  
15 pay arrangements between the visitor and the provider of  
16 care.

17 **SEC. 102. BENEFITS AND PORTABILITY.**

18          (a) IN GENERAL.—The health care benefits under  
19 this division cover all medically necessary services, includ-  
20 ing at least the following:

- 21           (1) Primary care and prevention.
- 22           (2) Inpatient care.
- 23           (3) Outpatient care.
- 24           (4) Emergency care.
- 25           (5) Prescription drugs.

- 1 (6) Durable medical equipment.
- 2 (7) Long-term care.
- 3 (8) Palliative care.
- 4 (9) Mental health services.
- 5 (10) The full scope of dental services (other
- 6 than cosmetic dentistry).
- 7 (11) Substance abuse treatment services.
- 8 (12) Chiropractic services.
- 9 (13) Basic vision care and vision correction
- 10 (other than laser vision correction for cosmetic pur-
- 11 poses).
- 12 (14) Hearing services, including coverage of
- 13 hearing aids.
- 14 (15) Podiatric care.

15 (b) PORTABILITY.—Such benefits are available  
16 through any licensed health care clinician anywhere in the  
17 United States that is legally qualified to provide the bene-  
18 fits.

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

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

23 (a) REQUIREMENT TO BE PUBLIC OR NON-PROF-  
24 IT.—

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

7           (2) CONVERSION OF INVESTOR-OWNED PRO-  
8           VIDERS.—For-profit providers of care opting to par-  
9           ticipate shall be required to convert to not-for-profit  
10          status.

11          (3) PRIVATE DELIVERY OF CARE REQUIRE-  
12          MENT.—For-profit providers of care that convert to  
13          non-profit status shall remain privately owned and  
14          operated entities.

15          (4) COMPENSATION FOR CONVERSION.—The  
16          owners of such for-profit providers shall be com-  
17          pensated for reasonable financial losses incurred as  
18          a result of the conversion from for-profit to non-  
19          profit status.

20          (5) FUNDING.—There are authorized to be ap-  
21          propriated from the Treasury such sums as are nec-  
22          essary to compensate investor-owned providers as  
23          provided for under paragraph (3).

24          (6) REQUIREMENTS.—The payments to owners  
25          of converting for-profit providers shall occur during

1 a 15-year period, through the sale of U.S. Treasury  
2 Bonds. Payment for conversions under paragraph  
3 (3) shall not be made for loss of business profits.

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

8 (b) QUALITY STANDARDS.—

9 (1) IN GENERAL.—Health care delivery facili-  
10 ties must meet State quality and licensing guidelines  
11 as a condition of participation under such program,  
12 including guidelines regarding safe staffing and  
13 quality of care.

14 (2) LICENSURE REQUIREMENTS.—Participating  
15 clinicians must be licensed in their State of practice  
16 and meet the quality standards for their area of  
17 care. No clinician whose license is under suspension  
18 or who is under disciplinary action in any State may  
19 be a participating provider.

20 (c) PARTICIPATION OF HEALTH MAINTENANCE OR-  
21 GANIZATIONS.—

22 (1) IN GENERAL.—Non-profit health mainte-  
23 nance organizations that deliver care in their own  
24 facilities and employ clinicians on a salaried basis  
25 may participate in the program and receive global

1 budgets or capitation payments as specified in sec-  
2 tion 202.

3 (2) EXCLUSION OF CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Other health maintenance  
4 organizations, including those which principally con-  
5 tract to pay for services delivered by non-employees,  
6 shall be classified as insurance plans. Such organiza-  
7 tions shall not be participating providers, and are  
8 subject to the regulations promulgated by reason of  
9 section 104(a) (relating to prohibition against dupli-  
10 cating coverage).  
11

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

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

16 (a) IN GENERAL.—It is unlawful for a private health  
17 insurer to sell health insurance coverage that duplicates  
18 the benefits provided under this division.

19 (b) CONSTRUCTION.—Nothing in this division shall  
20 be construed as prohibiting the sale of health insurance  
21 coverage for any additional benefits not covered by this  
22 division, such as for cosmetic surgery or other services and  
23 items that are not medically necessary.

1                   **TITLE II—FINANCES**  
2                   **Subtitle A—Budgeting and**  
3                   **Payments**

4 **SEC. 201. BUDGETING PROCESS.**

5           (a) ESTABLISHMENT OF OPERATING BUDGET AND  
6 CAPITAL EXPENDITURES BUDGET.—

7           (1) IN GENERAL.—To carry out this division  
8 there are established on an annual basis consistent  
9 with this title—

10                   (A) an operating budget, including  
11 amounts for optimal physician, nurse, and other  
12 health care professional staffing;

13                   (B) a capital expenditures budget;

14                   (C) reimbursement levels for providers con-  
15 sistent with subtitle B; and

16                   (D) a health professional education budget,  
17 including amounts for the continued funding of  
18 resident physician training programs.

19           (2) REGIONAL ALLOCATION.—After Congress  
20 appropriates amounts for the annual budget for the  
21 USNHC Program, the Director shall provide the re-  
22 gional offices with an annual funding allotment to  
23 cover the costs of each region's expenditures. Such  
24 allotment shall cover global budgets, reimbursements  
25 to clinicians, health professional education, and cap-

1       ital expenditures. Regional offices may receive addi-  
2       tional funds from the national program at the dis-  
3       cretion of the Director.

4       (b) OPERATING BUDGET.—The operating budget  
5 shall be used for—

6           (1) payment for services rendered by physicians  
7       and other clinicians;

8           (2) global budgets for institutional providers;

9           (3) capitation payments for capitated groups;

10       and

11           (4) administration of the Program.

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

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

16           (2) for major equipment purchases.

17       (d) PROHIBITION AGAINST CO-MINGLING OPER-  
18 ATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is pro-  
19 hibited to use funds under this division that are ear-  
20 marked—

21           (1) for operations for capital expenditures; or

22           (2) for capital expenditures for operations.

1 **SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLI-**  
2 **NICIANS.**

3 (a) **ESTABLISHING GLOBAL BUDGETS; MONTHLY**  
4 **LUMP SUM.—**

5 (1) **IN GENERAL.—**The USNHC Program,  
6 through its regional offices, shall pay each institu-  
7 tional provider of care, including hospitals, nursing  
8 homes, community or migrant health centers, home  
9 care agencies, or other institutional providers or pre-  
10 paid group practices, a monthly lump sum to cover  
11 all operating expenses under a global budget.

12 (2) **ESTABLISHMENT OF GLOBAL BUDGETS.—**  
13 The global budget of a provider shall be set through  
14 negotiations between providers, State directors, and  
15 regional directors, but are subject to the approval of  
16 the Director. The budget shall be negotiated annu-  
17 ally, based on past expenditures, projected changes  
18 in levels of services, wages and input, costs, a pro-  
19 vider's maximum capacity to provide care, and pro-  
20 posed new and innovative programs.

21 (b) **THREE PAYMENT OPTIONS FOR PHYSICIANS AND**  
22 **CERTAIN OTHER HEALTH PROFESSIONALS.—**

23 (1) **IN GENERAL.—**The Program shall pay phy-  
24 sicians, dentists, doctors of osteopathy, pharmacists,  
25 psychologists, chiropractors, doctors of optometry,  
26 nurse practitioners, nurse midwives, physicians' as-

1       sistants, and other advanced practice clinicians as li-  
2       censed and regulated by the States by the following  
3       payment methods:

4               (A) Fee for service payment under para-  
5       graph (2).

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

8               (C) Salaried positions within group prac-  
9       tices or non-profit health maintenance organiza-  
10      tions receiving capitation payments under para-  
11      graph (4).

12      (2) FEE FOR SERVICE.—

13              (A) IN GENERAL.—The Program shall ne-  
14      gotiate a simplified fee schedule that is fair and  
15      optimal with representatives of physicians and  
16      other clinicians, after close consultation with  
17      the National Board of Universal Quality and  
18      Access and regional and State directors. Ini-  
19      tially, the current prevailing fees or reimburse-  
20      ment would be the basis for the fee negotiation  
21      for all professional services covered under this  
22      division.

23              (B) CONSIDERATIONS.—In establishing  
24      such schedule, the Director shall take into con-  
25      sideration the following:

1 (i) The need for a uniform national  
2 standard.

3 (ii) The goal of ensuring that physi-  
4 cians, clinicians, pharmacists, and other  
5 medical professionals be compensated at a  
6 rate which reflects their expertise and the  
7 value of their services, regardless of geo-  
8 graphic region and past fee schedules.

9 (C) STATE PHYSICIAN PRACTICE REVIEW  
10 BOARDS.—The State director for each State, in  
11 consultation with representatives of the physi-  
12 cian community of that State, shall establish  
13 and appoint a physician practice review board  
14 to assure quality, cost effectiveness, and fair re-  
15 imbursements for physician delivered services.

16 (D) FINAL GUIDELINES.—The Director  
17 shall be responsible for promulgating final  
18 guidelines to all providers.

19 (E) BILLING.—Under this division physi-  
20 cians shall submit bills to the regional director  
21 on a simple form, or via computer. Interest  
22 shall be paid to providers who are not reim-  
23 bursed within 30 days of submission.

24 (F) NO BALANCE BILLING.—Licensed  
25 health care clinicians who accept any payment

1 from the USNHC Program may not bill any  
2 patient for any covered service.

3 (G) UNIFORM COMPUTER ELECTRONIC  
4 BILLING SYSTEM.—The Director shall create a  
5 uniform computerized electronic billing system,  
6 including those areas of the United States  
7 where electronic billing is not yet established.

8 (3) SALARIES WITHIN INSTITUTIONS RECEIVING  
9 GLOBAL BUDGETS.—

10 (A) IN GENERAL.—In the case of an insti-  
11 tution, such as a hospital, health center, group  
12 practice, community and migrant health center,  
13 or a home care agency that elects to be paid a  
14 monthly global budget for the delivery of health  
15 care as well as for education and prevention  
16 programs, physicians and other clinicians em-  
17 ployed by such institutions shall be reimbursed  
18 through a salary included as part of such a  
19 budget.

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

23 (4) SALARIES WITHIN CAPITATED GROUPS.—

24 (A) IN GENERAL.—Health maintenance or-  
25 ganizations, group practices, and other institu-

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

2 (a) ALLOTMENT FOR REGIONS.—The Program shall  
3 provide for each region a single budgetary allotment to  
4 cover a full array of long-term care services under this  
5 division.

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

10 (c) BASIS FOR BUDGETS.—Budgets for long-term  
11 care services under this section shall be based on past ex-  
12 penditures, financial and clinical performance, utilization,  
13 and projected changes in service, wages, and other related  
14 factors.

15 (d) FAVORING NON-INSTITUTIONAL CARE.—All ef-  
16 forts shall be made under this division to provide long-  
17 term care in a home- or community-based setting, as op-  
18 posed to institutional care.

19 **SEC. 204. MENTAL HEALTH SERVICES.**

20 (a) IN GENERAL.—The Program shall provide cov-  
21 erage for all medically necessary mental health care on  
22 the same basis as the coverage for other conditions. Li-  
23 censed mental health clinicians shall be paid in the same  
24 manner as specified for other health professionals, as pro-  
25 vided for in section 202(b).

1           tions may elect to be paid capitation payments  
2           to cover all outpatient, physician, and medical  
3           home care provided to individuals enrolled to  
4           receive benefits through the organization or en-  
5           tity.

6           (B) SCOPE.—Such capitation may include  
7           the costs of services of licensed physicians and  
8           other licensed, independent practitioners pro-  
9           vided to inpatients. Other costs of inpatient and  
10          institutional care shall be excluded from capita-  
11          tion payments, and shall be covered under insti-  
12          tutions' global budgets.

13          (C) PROHIBITION OF SELECTIVE ENROLL-  
14          MENT.—Patients shall be permitted to enroll or  
15          disenroll from such organizations or entities  
16          without discrimination and with appropriate no-  
17          tice.

18          (D) HEALTH MAINTENANCE ORGANIZA-  
19          TIONS.—Under this division—

20               (i) health maintenance organizations  
21               shall be required to reimburse physicians  
22               based on a salary; and

23               (ii) financial incentives between such  
24               organizations and physicians based on uti-  
25               lization are prohibited.

1 (b) FAVORING COMMUNITY-BASED CARE.—The  
2 USNHC Program shall cover supportive residences, occu-  
3 pational therapy, and ongoing mental health and coun-  
4 seling services outside the hospital for patients with seri-  
5 ous mental illness. In all cases the highest quality and  
6 most effective care shall be delivered, and, for some indi-  
7 viduals, this may mean institutional care.

8 **SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS,**  
9 **MEDICAL SUPPLIES, AND MEDICALLY NEC-**  
10 **CESSARY ASSISTIVE EQUIPMENT.**

11 (a) NEGOTIATED PRICES.—The prices to be paid  
12 each year under this division for covered pharmaceuticals,  
13 medical supplies, and medically necessary assistive equip-  
14 ment shall be negotiated annually by the Program.

15 (b) PRESCRIPTION DRUG FORMULARY.—

16 (1) IN GENERAL.—The Program shall establish  
17 a prescription drug formulary system, which shall  
18 encourage best-practices in prescribing and discour-  
19 age the use of ineffective, dangerous, or excessively  
20 costly medications when better alternatives are avail-  
21 able.

22 (2) PROMOTION OF USE OF GENERICS.—The  
23 formulary shall promote the use of generic medica-  
24 tions but allow the use of brand-name and off-for-  
25 mulary medications.

1           (3) FORMULARY UPDATES AND PETITION  
2           RIGHTS.—The formulary shall be updated frequently  
3           and clinicians and patients may petition their region  
4           or the Director to add new pharmaceuticals or to re-  
5           move ineffective or dangerous medications from the  
6           formulary.

7   **SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSE-**  
8                                   **MENT LEVELS.**

9           Reimbursement levels under this subtitle shall be set  
10          after close consultation with regional and State Directors  
11          and after the annual meeting of National Board of Uni-  
12          versal Quality and Access.

13                               **Subtitle B—Funding**

14   **SEC. 211. OVERVIEW: FUNDING THE USNHC PROGRAM.**

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

17          (b) USNHC TRUST FUND.—There shall be estab-  
18          lished a USNHC Trust Fund in which funds provided  
19          under this section are deposited and from which expendi-  
20          tures under this division are made.

21          (c) FUNDING.—

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

1 (A) Existing sources of Federal Govern-  
2 ment revenues for health care.

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

5 (C) Instituting a modest and progressive  
6 excise tax on payroll and self-employment in-  
7 come.

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

10 (2) SYSTEM SAVINGS AS A SOURCE OF FINANC-  
11 ING.—Funding otherwise required for the Program  
12 is reduced as a result of—

13 (A) vastly reducing paperwork;

14 (B) requiring a rational bulk procurement  
15 of medications under section 205(a); and

16 (C) improved access to preventive health  
17 care.

18 (3) ADDITIONAL ANNUAL APPROPRIATIONS TO  
19 USNHC PROGRAM.—Additional sums are authorized  
20 to be appropriated annually as needed to maintain  
21 maximum quality, efficiency, and access under the  
22 Program.

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

24 Notwithstanding any other provision of law, there are  
25 hereby transferred and appropriated to carry out this divi-

1 sion, amounts from the Treasury equivalent to the  
2 amounts the Secretary estimates would have been appro-  
3 priated and expended for Federal public health care pro-  
4 grams, including funds that would have been appropriated  
5 under the Medicare program under title XVIII of the So-  
6 cial Security Act, under the Medicaid program under title  
7 XIX of such Act, and under the Children's Health Insur-  
8 ance Program under title XXI of such Act.

### 9 **TITLE III—ADMINISTRATION**

#### 10 **SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DI-** 11 **RECTOR.**

12 (a) **IN GENERAL.**—Except as otherwise specifically  
13 provided, this division shall be administered by the Sec-  
14 retary through a Director appointed by the Secretary.

15 (b) **LONG-TERM CARE.**—The Director shall appoint  
16 a director for long-term care who shall be responsible for  
17 administration of this division and ensuring the avail-  
18 ability and accessibility of high quality long-term care  
19 services.

20 (c) **MENTAL HEALTH.**—The Director shall appoint a  
21 director for mental health who shall be responsible for ad-  
22 ministration of this division and ensuring the availability  
23 and accessibility of high quality mental health services.

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

2 The Director shall appoint a director for an Office  
3 of Quality Control. Such director shall, after consultation  
4 with state and regional directors, provide annual rec-  
5 ommendations to Congress, the President, the Secretary,  
6 and other Program officials on how to ensure the highest  
7 quality health care service delivery. The director of the Of-  
8 fice of Quality Control shall conduct an annual review on  
9 the adequacy of medically necessary services, and shall  
10 make recommendations of any proposed changes to the  
11 Congress, the President, the Secretary, and other USNHC  
12 Program officials.

13 **SEC. 303. REGIONAL AND STATE ADMINISTRATION; EM-**  
14 **PLOYMENT OF DISPLACED CLERICAL WORK-**  
15 **ERS.**

16 (a) **ESTABLISHMENT OF USNHC PROGRAM RE-**  
17 **REGIONAL OFFICES.**—The Secretary shall establish and  
18 maintain USNHC regional offices for the purpose of dis-  
19 tributing funds to providers of care. Whenever possible,  
20 the Secretary should incorporate pre-existing Medicare in-  
21 frastructure for this purpose.

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

24 (1) one regional director appointed by the Di-  
25 rector; and

1           (2) for each State in the region, a deputy direc-  
2           tor (in this division referred to as a “State Direc-  
3           tor”) appointed by the governor of that State.

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

6           (1) coordinating funding to health care pro-  
7           viders and physicians; and

8           (2) coordinating billing and reimbursements  
9           with physicians and health care providers through a  
10          State-based reimbursement system.

11          (d) STATE DIRECTOR’S DUTIES.—Each State Direc-  
12         tor shall be responsible for the following duties:

13                 (1) Providing an annual state health care needs  
14                 assessment report to the National Board of Uni-  
15                 versal Quality and Access, and the regional board,  
16                 after a thorough examination of health needs, in  
17                 consultation with public health officials, clinicians,  
18                 patients, and patient advocates.

19                 (2) Health planning, including oversight of the  
20                 placement of new hospitals, clinics, and other health  
21                 care delivery facilities.

22                 (3) Health planning, including oversight of the  
23                 purchase and placement of new health equipment to  
24                 ensure timely access to care and to avoid duplica-  
25                 tion.

1           (4) Submitting global budgets to the regional  
2           director.

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

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

10          (7) Reviewing program disbursements on a  
11          quarterly basis and recommending needed adjust-  
12          ments in fee schedules needed to achieve budgetary  
13          targets and assure adequate access to needed care.

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

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

22                 (2) shall be eligible to receive two years of  
23                 USNHC employment transition benefits with each  
24                 year's benefit equal to salary earned during the last

1 12 months of employment, but shall not exceed  
2 \$100,000 per year.

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

7 (g) ANNUAL APPROPRIATIONS TO USNHC EMPLOY-  
8 MENT TRANSITION FUND.—Sums are authorized to be ap-  
9 propriated annually as needed to fund the USNHC Em-  
10 ployment Transition Benefits.

11 (h) RETENTION OF RIGHT TO UNEMPLOYMENT BEN-  
12 EFITS.—Nothing in this section shall be interpreted as a  
13 waiver of USNHC Employment Transition benefit recipi-  
14 ents' right to receive Federal and State unemployment  
15 benefits.

16 **SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD**  
17 **SYSTEM.**

18 (a) IN GENERAL.—The Secretary shall create a  
19 standardized, confidential electronic patient record system  
20 in accordance with laws and regulations to maintain accu-  
21 rate patient records and to simplify the billing process,  
22 thereby reducing medical errors and bureaucracy.

23 (b) PATIENT OPTION.—Notwithstanding that all bill-  
24 ing shall be preformed electronically, patients shall have

1 the option of keeping any portion of their medical records  
2 separate from their electronic medical record.

3 **SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND**  
4 **ACCESS.**

5 (a) **ESTABLISHMENT.—**

6 (1) **IN GENERAL.—**There is established a Na-  
7 tional Board of Universal Quality and Access (in  
8 this section referred to as the “Board”) consisting  
9 of 15 members appointed by the President, by and  
10 with the advice and consent of the Senate.

11 (2) **QUALIFICATIONS.—**The appointed members  
12 of the Board shall include at least one of each of the  
13 following:

14 (A) Health care professionals.

15 (B) Representatives of institutional pro-  
16 viders of health care.

17 (C) Representatives of health care advo-  
18 cacy groups.

19 (D) Representatives of labor unions.

20 (E) Citizen patient advocates.

21 (3) **TERMS.—**Each member shall be appointed  
22 for a term of 6 years, except that the President shall  
23 stagger the terms of members initially appointed so  
24 that the term of no more than 3 members expires  
25 in any year.

1 (4) PROHIBITION ON CONFLICTS OF INTER-  
2 EST.—No member of the Board shall have a finan-  
3 cial conflict of interest with the duties before the  
4 Board.

5 (b) DUTIES.—

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

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

12 (A) Access to care.

13 (B) Quality improvement.

14 (C) Efficiency of administration.

15 (D) Adequacy of budget and funding.

16 (E) Appropriateness of reimbursement lev-  
17 els of physicians and other providers.

18 (F) Capital expenditure needs.

19 (G) Long-term care.

20 (H) Mental health and substance abuse  
21 services.

22 (I) Staffing levels and working conditions  
23 in health care delivery facilities.

24 (3) ESTABLISHMENT OF UNIVERSAL, BEST  
25 QUALITY STANDARD OF CARE.—The Board shall

1 specifically establish a universal, best quality of  
2 standard of care with respect to—

3 (A) appropriate staffing levels;

4 (B) appropriate medical technology;

5 (C) design and scope of work in the health  
6 workplace;

7 (D) best practices; and

8 (E) salary level and working conditions of  
9 physicians, clinicians, nurses, other medical pro-  
10 fessionals, and appropriate support staff.

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

15 (c) COMPENSATION, ETC.—The following provisions  
16 of section 1805 of the Social Security Act shall apply to  
17 the Board in the same manner as they apply to the Medi-  
18 care Payment Assessment Commission (except that any  
19 reference to the Commission or the Comptroller General  
20 shall be treated as references to the Board and the Sec-  
21 retary, respectively):

22 (1) Subsection (c)(4) (relating to compensation  
23 of Board members).

24 (2) Subsection (c)(5) (relating to chairman and  
25 vice chairman):

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

2 (4) Subsection (d) (relating to director and  
3 staff; experts and consultants).

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

5 **TITLE IV—ADDITIONAL**  
6 **PROVISIONS**

7 **SEC. 401. PUBLIC HEALTH AND PREVENTION.**

8 It is the intent of this division that the Program at  
9 all times stress the importance of good public health  
10 through the prevention of diseases.

11 **SEC. 402. REDUCTION IN HEALTH DISPARITIES.**

12 It is the intent of this division to reduce health dis-  
13 parities by race, ethnicity, income and geographic region,  
14 and to provide high quality, cost-effective, culturally ap-  
15 propriate care to all individuals regardless of race, eth-  
16 nicity, sexual orientation, or language.

17 **TITLE V—EFFECTIVE DATE**

18 **SEC. 501. EFFECTIVE DATE.**

19 Except as otherwise specifically provided, this divi-  
20 sion shall take effect on the first day of the first year that  
21 begins more than 1 year after the date of the enactment  
22 of this division, and shall apply to items and services fur-  
23 nished on or after such date.

