I

115TH 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 24, 2017

Mr. CONYERS (for himself, Mr. HUFFMAN, Ms. LEE, Ms. CLARK of Massachusetts, Mr. CLAY, Mr. CLYBURN, Mr. COHEN, Mr. CUMMINGS, Mr. ELLISON, Mr. ENGEL, Mr. GRIJALVA, Ms. JACKSON LEE, Mr. TED LIEU of California, Ms. NORTON, Mr. POCAN, Ms. ROYBAL-ALLARD, Mr. RYAN of Ohio, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. TAKANO, Ms. KAPTUR, Mr. JEFFRIES, Mr. LEWIS of Georgia, Mr. TONKO, Mr. THOMPSON of Mississippi, Ms. SCHAKOWSKY, Mrs. WATSON COLEMAN, Mr. WELCH, Mrs. NAPOLITANO, Mr. BRADY of Pennsylvania, Mr. CARTWRIGHT, Ms. PINGREE, Mrs. LAWRENCE, Mr. GARAMENDI, Ms. LOFGREN, Mr. BLUMENAUER, Ms. KELLY of Illinois, Ms. CLARKE of New York, Mr. NOLAN, Mr. CLEAVER, Mr. HASTINGS, Ms. JUDY CHU of California, Mr. MCGOVERN, Mr. JOHNSON of Georgia, Mr. NADLER, Ms. JAYAPAL, Mr. MICHAEL F. DOYLE of Pennsylvania, Ms. ADAMS, Mrs. BEATTY, Mr. AL GREEN of Texas, Mr. DESAULNIER, and Ms. MOORE) 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,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 "Expanded & Improved Medicare For All Act".

6 (b) TABLE OF CONTENTS.—The table of contents of
7 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 Medicare For All 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) MEDICARE FOR ALL PROGRAM; PROGRAM.—
4 The terms ''Medicare For All Program'' and ''Pro-
5 gram'' mean the program of benefits provided under
6 this Act and, unless the context otherwise requires,
7 the Secretary with respect to functions relating to
8 carrying out 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.

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.

TITLE I—ELIGIBILITY AND BENEFITS

SEC. 101. ELIGIBILITY AND REGISTRATION.

(a) IN GENERAL.—All individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number in the mail. An individual's Social Security number shall not be used for purposes of registration under this section.

(b) REGISTRATION.—Individuals and families shall receive a Medicare For All Program Card in the mail, after filling out a Medicare For All Program application form at a health care provider. Such application form shall be no more than 2 pages long.

(c) PRESUMPTION.—Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive a Medicare For All Program Card and have payment made for such benefits.

(d) RESIDENCY CRITERIA.—The Secretary shall promulgate a rule that provides criteria for determining resi-

1 dency for eligibility purposes under the Medicare For All
2 Program.
3 (e) COVERAGE FOR VISITORS.—The Secretary shall
4 promulgate a rule regarding visitors from other countries
5 who seek premeditated non-emergency surgical proce-
6 dures. Such a rule should facilitate the establishment of
7 country-to-country reimbursement arrangements or self
8 pay arrangements between the visitor and the provider of
9 care.

10 **SEC. 102. BENEFITS AND PORTABILITY.**

11 (a) IN GENERAL.—The health care benefits under
12 this Act cover all medically necessary services, including
13 at least the following:
14 (1) Primary care and prevention.
15 (2) Approved dietary and nutritional therapies.
16 (3) Inpatient care.
17 (4) Outpatient care.
18 (5) Emergency care.
19 (6) Prescription drugs.
20 (7) Durable medical equipment.
21 (8) Long-term care.
22 (9) Palliative care.
23 (10) Mental health services.

1 (11) The full scope of dental services, services,
2 including periodontics, oral surgery, and
3 endodontics, but not including cosmetic dentistry.
4 (12) Substance abuse treatment services.
5 (13) Chiropractic services, not including elec-
6 trical stimulation.
7 (14) Basic vision care and vision correction
8 (other than laser vision correction for cosmetic pur-
9 poses).
10 (15) Hearing services, including coverage of
11 hearing aids.
12 (16) Podiatric care.
13 (b) PORTABILITY.—Such benefits are available
14 through any licensed health care clinician anywhere in the
15 United States that is legally qualified to provide the bene-
16 fits.
17 (c) NO COST-SHARING.—No deductibles, copay-
18 ments, coinsurance, or other cost-sharing shall be imposed
19 with respect to covered benefits.
20 **SEC. 103. QUALIFICATION OF PARTICIPATING PROVIDERS.**
21 (a) REQUIREMENT TO BE PUBLIC OR NON-PROF-
22 IT.—
23 (1) IN GENERAL.—No institution may be a par-
24 ticipating provider unless it is a public or not-for-
25 profit institution. Private physicians, private clinics,

1 and private health care providers shall continue to
2 operate as private entities, but are prohibited from
3 being investor owned.

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

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

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

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

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

1 (7) MECHANISM FOR CONVERSION PROCESS.—
2 The Secretary shall promulgate a rule to provide a
3 mechanism to further the timely, efficient, and fea-
4 sible conversion of for-profit providers of care.
5 (b) QUALITY STANDARDS.—
6 (1) IN GENERAL.—Health care delivery facili-
7 ties must meet State quality and licensing guidelines
8 as a condition of participation under such program,
9 including guidelines regarding safe staffing and
10 quality of care.
11 (2) LICENSURE REQUIREMENTS.—Participating
12 clinicians must be licensed in their State of practice
13 and meet the quality standards for their area of
14 care. No clinician whose license is under suspension
15 or who is under disciplinary action in any State may
16 be a participating provider.
17 (c) PARTICIPATION OF HEALTH MAINTENANCE OR-
18 GANIZATIONS.—
19 (1) IN GENERAL.—Non-profit health mainte-
20 nance organizations that deliver care in their own
21 facilities and employ clinicians on a salaried basis
22 may participate in the program and receive global
23 budgets or capitation payments as specified in sec-
24 tion 202.

1 (2) EXCLUSION OF CERTAIN HEALTH MAINTE-
2 NANCE ORGANIZATIONS.—Other health maintenance
3 organizations which principally contract to pay for
4 services delivered by non-employees shall be classi-
5 fied as insurance plans. Such organizations shall not
6 be participating providers, and are subject to the
7 regulations promulgated by reason of section 104(a)
8 (relating to prohibition against duplicating cov-
9 erage).

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

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

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

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

TITLE II—FINANCES

Subtitle A—Budgeting and Payments

SEC. 201. BUDGETING PROCESS.

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

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

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

(B) a capital expenditures budget;

(C) reimbursement levels for providers consistent with subtitle B; and

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

(2) REGIONAL ALLOCATION.—After Congress appropriates amounts for the annual budget for the Medicare For All Program, the Director shall provide the regional offices with an annual funding allotment to cover the costs of each region's expenditures. Such allotment shall cover global budgets, reimbursements to clinicians, health professional edu-

1 cation, and capital expenditures. Regional offices
2 may receive additional funds from the national pro-
3 gram at the discretion 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 Act that are earmarked—
20 (1) for operations for capital expenditures; or
21 (2) for capital expenditures for operations.
22 **SEC. 202. PAYMENT OF PROVIDERS AND HEALTH CARE CLI-**
23 **NICIANS.**
24 (a) ESTABLISHING GLOBAL BUDGETS; MONTHLY
25 LUMP SUM.—

1 (1) IN GENERAL.—The Medicare For All Pro-
2 gram, through its regional offices, shall pay each in-
3 stitutional provider of care, including hospitals,
4 nursing homes, community or migrant health cen-
5 ters, home care agencies, or other institutional pro-
6 viders or pre-paid group practices, a monthly lump
7 sum to cover all operating expenses under a global
8 budget.
9 (2) ESTABLISHMENT OF GLOBAL BUDGETS.—
10 The global budget of a provider shall be set through
11 negotiations between providers, State directors, and
12 regional directors, but are subject to the approval of
13 the Director. The budget shall be negotiated annu-
14 ally, based on past expenditures, projected changes
15 in levels of services, wages and input, costs, a pro-
16 vider's maximum capacity to provide care, and pro-
17 posed new and innovative programs.
18 (b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND
19 CERTAIN OTHER HEALTH PROFESSIONALS.—
20 (1) IN GENERAL.—The Program shall pay phy-
21 sicians, dentists, doctors of osteopathy, pharmacists,
22 psychologists, chiropractors, doctors of optometry,
23 nurse practitioners, nurse midwives, physicians' as-
24 sistants, and other advanced practice clinicians as li-

1 censed and regulated by the States by the following
2 payment methods:
3 (A) Fee for service payment under para-
4 graph (2).
5 (B) Salaried positions in institutions re-
6 ceiving global budgets under paragraph (3).
7 (C) Salaried positions within group prac-
8 tices or non-profit health maintenance organiza-
9 tions receiving capitation payments under para-
10 graph (4).
11 (2) FEE FOR SERVICE.—
12 (A) IN GENERAL.—The Program shall ne-
13 gotiate a simplified fee schedule that is fair and
14 optimal with representatives of physicians and
15 other clinicians, after close consultation with
16 the National Board of Universal Quality and
17 Access and regional and State directors. Ini-
18 tially, the current prevailing fees or reimburse-
19 ment would be the basis for the fee negotiation
20 for all professional services covered under this
21 Act.
22 (B) CONSIDERATIONS.—In establishing
23 such schedule, the Director shall take into con-
24 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 Act physicians
20 shall submit bills to the regional director on a
21 simple form, or via computer. Interest shall be
22 paid to providers who are not reimbursed within
23 30 days of submission.
24 (F) NO BALANCE BILLING.—Licensed
25 health care clinicians who accept any payment

1 from the Medicare For All Program may not
2 bill any 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 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 Act—

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.

SEC. 203. PAYMENT FOR LONG-TERM CARE.

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

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

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

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

SEC. 204. MENTAL HEALTH SERVICES.

(a) IN GENERAL.—The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions. Licensed mental health clinicians shall be paid in the same manner as specified for other health professionals, as provided for in section 202(b).

(b) FAVORING COMMUNITY-BASED CARE.—The Medicare For All Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some individuals, this may mean institutional care.

SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS, MEDICAL SUPPLIES, AND MEDICALLY NECESSARY ASSISTIVE EQUIPMENT.

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

(b) PRESCRIPTION DRUG FORMULARY.—

(1) IN GENERAL.—The Program shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(2) PROMOTION OF USE OF GENERICS.—The formulary shall promote the use of generic medications but allow the use of brand-name and off-formulary medications.

(3) FORMULARY UPDATES AND PETITION RIGHTS.—The formulary shall be updated frequently and clinicians and patients may petition their region or the Director to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSEMENT LEVELS.

Reimbursement levels under this subtitle shall be set after close consultation with regional and State Directors and after the annual meeting of National Board of Universal Quality and Access.

Subtitle B—Funding

SEC. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.

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

(b) MEDICARE FOR ALL TRUST FUND.—There shall be established a Medicare For All 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 Medicare For All Trust Fund amounts sufficient to carry out this Act 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 modest tax on unearned
9 income.
10 (E) Instituting a small tax on stock and
11 bond transactions.
12 (2) SYSTEM SAVINGS AS A SOURCE OF FINANC-
13 ING.—Funding otherwise required for the Program
14 is reduced as a result of—
15 (A) vastly reducing paperwork;
16 (B) requiring a rational bulk procurement
17 of medications under section 205(a); and
18 (C) improved access to preventive health
19 care.
20 (3) ADDITIONAL ANNUAL APPROPRIATIONS TO
21 MEDICARE FOR ALL PROGRAM.—Additional sums are
22 authorized to be appropriated annually as needed to
23 maintain maximum quality, efficiency, and access
24 under the Program.

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

2 Notwithstanding any other provision of law, there are
3 hereby transferred and appropriated to carry out this Act,
4 amounts from the Treasury equivalent to the amounts the
5 Secretary estimates would have been appropriated and ex-
6 pended for Federal public health care programs, including
7 funds that would have been appropriated under the Medi-
8 care program under title XVIII of the Social Security Act,
9 under the Medicaid program under title XIX of such Act,
10 and under the Children's Health Insurance Program
11 under title XXI of such Act.

12 # TITLE III—ADMINISTRATION

13 **SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DI-**
14 **RECTOR.**

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

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

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

SEC. 302. OFFICE OF QUALITY CONTROL.

The Director shall appoint a director for an Office of Quality Control. Such director shall, after consultation with State and regional directors, provide annual recommendations to Congress, the President, the Secretary, and other Program officials on how to ensure the highest quality health care service delivery. The director of the Office of Quality Control shall conduct an annual review on the adequacy of medically necessary services, and shall make recommendations of any proposed changes to the Congress, the President, the Secretary, and other Medicare For All Program officials.

SEC. 303. REGIONAL AND STATE ADMINISTRATION; EMPLOYMENT OF DISPLACED CLERICAL WORKERS.

(a) ESTABLISHMENT OF MEDICARE FOR ALL PROGRAM REGIONAL OFFICES.—The Secretary shall establish and maintain Medicare For All regional offices for the purpose of distributing funds to providers of care. Whenever possible, the Secretary should incorporate pre-existing Medicare infrastructure for this purpose.

(b) APPOINTMENT OF REGIONAL AND STATE DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Director; and

1 (2) for each State in the region, a deputy direc-
2 tor (in this Act referred to as a ''State Director'')
3 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 Medicare For All employment transition benefits
24 with each year's benefit equal to salary earned dur-

1 ing the last 12 months of employment, but shall not
2 exceed $100,000 per year.
3 (f) ESTABLISHMENT OF MEDICARE FOR ALL EM-
4 PLOYMENT TRANSITION FUND.—The Secretary shall es-
5 tablish a trust fund from which expenditures shall be
6 made to recipients of the benefits allocated in subsection
7 (e).
8 (g) ANNUAL APPROPRIATIONS TO MEDICARE FOR
9 ALL EMPLOYMENT TRANSITION FUND.—Sums are au-
10 thorized to be appropriated annually as needed to fund
11 the Medicare For All Employment Transition Benefits.
12 (h) RETENTION OF RIGHT TO UNEMPLOYMENT BEN-
13 EFITS.—Nothing in this section shall be interpreted as a
14 waiver of Medicare For All Employment Transition ben-
15 efit recipients' right to receive Federal and State unem-
16 ployment benefits.

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

19 (a) IN GENERAL.—The Secretary shall create a
20 standardized, confidential electronic patient record system
21 in accordance with laws and regulations to maintain accu-
22 rate patient records and to simplify the billing process,
23 thereby reducing medical errors and bureaucracy.
24 (b) PATIENT OPTION.—Notwithstanding that all bill-
25 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).

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

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

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

TITLE IV—ADDITIONAL PROVISIONS

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

(a) VA HEALTH PROGRAMS.—This Act provides for health programs of the Department of Veterans' Affairs to initially remain independent for the 10-year period that begins on the date of the establishment of the Medicare For All Program. After such 10-year period, the Congress shall reevaluate whether such programs shall remain independent or be integrated into the Medicare For All Program.

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

SEC. 402. PUBLIC HEALTH AND PREVENTION.

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

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

2 It is the intent of this Act to reduce health disparities
3 by race, ethnicity, income and geographic region, and to
4 provide high quality, cost-effective, culturally appropriate
5 care to all individuals regardless of race, ethnicity, sexual
6 orientation, or language.

7 TITLE V—EFFECTIVE DATE

8 **SEC. 501. EFFECTIVE DATE.**

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

○