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S.L.C.

Pending

Steve Daines

AMENDMENT NO._____ Calendar No._____

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

IN THE SENATE OF THE UNITED STATES—115th Cong., 1st Sess.

(no.) H.R. 1628

McConnell

AMENDMENT Nº 0340 of the

By Daines r 2017.

To: AMDT No 267 ___ and

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Mr. Daines to the amendment (No. 267) proposed by Mr. MCCONNELL

Viz: Strike all after the first word and

1 ~~In lieu of the matter proposed to be inserted~~, insert

2 the following:

3 **SEC. 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.

AS MODIFIED

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.

(2) NATIONAL BOARD OF UNIVERSAL QUALITY AND ACCESS.—The term "National Board of Universal Quality and Access" means such Board established under section 305.

(3) REGIONAL OFFICE.—The term "regional office" means a regional office established under section 303.

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

(5) DIRECTOR.—The term "Director" means, in relation to the Program, the Director appointed 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,

1 after filling out a Medicare For All Program application
2 form at a health care provider. Such application form shall
3 be no more than 2 pages long.

4 (c) PRESUMPTION.—Individuals who present them-
5 selves for covered services from a participating provider
6 shall be presumed to be eligible for benefits under this Act,
7 but shall complete an application for benefits in order to
8 receive a Medicare For All Program Card and have pay-
9 ment made for such benefits.

10 (d) RESIDENCY CRITERIA.—The Secretary shall pro-
11 mulgate a rule that provides criteria for determining resi-
12 dency for eligibility purposes under the Medicare For All
13 Program.

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

21 **SEC. 102. BENEFITS AND PORTABILITY.**

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

25 (1) Primary care and prevention.

1 (2) Approved dietary and nutritional therapies.

2 (3) Inpatient care.

3 (4) Outpatient care.

4 (5) Emergency care.

5 (6) Prescription drugs.

6 (7) Durable medical equipment.

7 (8) Long-term care.

8 (9) Palliative care.

9 (10) Mental health services.

10 (11) The full scope of dental services, services,
11 including periodontics, oral surgery, and
12 endodontics, but not including cosmetic dentistry.

13 (12) Substance abuse treatment services.

14 (13) Chiropractic services, not including elec-
15 trical stimulation.

16 (14) Basic vision care and vision correction
17 (other than laser vision correction for cosmetic pur-
18 poses).

19 (15) Hearing services, including coverage of
20 hearing aids.

21 (16) Podiatric care.

22 (b) PORTABILITY.—Such benefits are available
23 through any licensed health care clinician anywhere in the
24 United States that is legally qualified to provide the bene-
25 fits.

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

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

5 (a) REQUIREMENT TO BE PUBLIC OR NON-PROF-
6 IT.—

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

13 (2) CONVERSION OF INVESTOR-OWNED PRO-
14 VIDERS.—For-profit providers of care opting to par-
15 ticipate shall be required to convert to not-for-profit
16 status.

17 (3) PRIVATE DELIVERY OF CARE REQUIRE-
18 MENT.—For-profit providers of care that convert to
19 non-profit status shall remain privately owned and
20 operated entities.

21 (4) COMPENSATION FOR CONVERSION.—The
22 owners of such for-profit providers shall be com-
23 pensated for reasonable financial losses incurred as
24 a result of the conversion from for-profit to non-
25 profit status.

1 (5) FUNDING.—There are authorized to be ap-
2 propriated from the Treasury such sums as are nec-
3 essary to compensate investor-owned providers as
4 provided for under paragraph (3).
5 (6) REQUIREMENTS.—The payments to owners
6 of converting for-profit providers shall occur during
7 a 15-year period, through the sale of U.S. Treasury
8 Bonds. Payment for conversions under paragraph
9 (3) shall not be made for loss of business profits.
10 (7) MECHANISM FOR CONVERSION PROCESS.—
11 The Secretary shall promulgate a rule to provide a
12 mechanism to further the timely, efficient, and fea-
13 sible conversion of for-profit providers of care.
14 (b) QUALITY STANDARDS.—
15 (1) IN GENERAL.—Health care delivery facili-
16 ties must meet State quality and licensing guidelines
17 as a condition of participation under such program,
18 including guidelines regarding safe staffing and
19 quality of care.
20 (2) LICENSURE REQUIREMENTS.—Participating
21 clinicians must be licensed in their State of practice
22 and meet the quality standards for their area of
23 care. No clinician whose license is under suspension
24 or who is under disciplinary action in any State may
25 be a participating provider.

1 (c) PARTICIPATION OF HEALTH MAINTENANCE OR-
2 GANIZATIONS.—
3 (1) IN GENERAL.—Non-profit health mainte-
4 nance organizations that deliver care in their own
5 facilities and employ clinicians on a salaried basis
6 may participate in the program and receive global
7 budgets or capitation payments as specified in sec-
8 tion 202.
9 (2) EXCLUSION OF CERTAIN HEALTH MAINTE-
10 NANCE ORGANIZATIONS.—Other health maintenance
11 organizations which principally contract to pay for
12 services delivered by non-employees shall be classi-
13 fied as insurance plans. Such organizations shall not
14 be participating providers, and are subject to the
15 regulations promulgated by reason of section 104(a)
16 (relating to prohibition against duplicating cov-
17 erage).
18 (d) FREEDOM OF CHOICE.—Patients shall have free
19 choice of participating physicians and other clinicians,
20 hospitals, and inpatient care facilities.
21 **SEC. 104. PROHIBITION AGAINST DUPLICATING COVERAGE.**
22 (a) IN GENERAL.—It is unlawful for a private health
23 insurer to sell health insurance coverage that duplicates
24 the benefits provided under this Act.

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

6 TITLE II—FINANCES

7 Subtitle A—Budgeting and 8 Payments

9 SEC. 201. BUDGETING PROCESS.

10 (a) ESTABLISHMENT OF OPERATING BUDGET AND
11 CAPITAL EXPENDITURES BUDGET.—
12 (1) IN GENERAL.—To carry out this Act there
13 are established on an annual basis consistent with
14 this title—
15 (A) an operating budget, including
16 amounts for optimal physician, nurse, and other
17 health care professional staffing;
18 (B) a capital expenditures budget;
19 (C) reimbursement levels for providers con-
20 sistent with subtitle B; and
21 (D) a health professional education budget,
22 including amounts for the continued funding of
23 resident physician training programs.
24 (2) REGIONAL ALLOCATION.—After Congress
25 appropriates amounts for the annual budget for the

1 Medicare For All Program, the Director shall pro-
2 vide the regional offices with an annual funding al-
3 lotment to cover the costs of each region's expendi-
4 tures. Such allotment shall cover global budgets, re-
5 imbursements to clinicians, health professional edu-
6 cation, and capital expenditures. Regional offices
7 may receive additional funds from the national pro-
8 gram at the discretion of the Director.
9 (b) OPERATING BUDGET.—The operating budget
10 shall be used for—
11 (1) payment for services rendered by physicians
12 and other clinicians;
13 (2) global budgets for institutional providers;
14 (3) capitation payments for capitated groups;
15 and
16 (4) administration of the Program.
17 (c) CAPITAL EXPENDITURES BUDGET.—The capital
18 expenditures budget shall be used for funds needed for—
19 (1) the construction or renovation of health fa-
20 cilities; and
21 (2) for major equipment purchases.
22 (d) PROHIBITION AGAINST CO-MINGLING OPER-
23 ATIONS AND CAPITAL IMPROVEMENT FUNDS.—It is pro-
24 hibited to use funds under this Act that are earmarked—
25 (1) for operations for capital expenditures; or

1 (2) for capital expenditures for operations.

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

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

6 (1) IN GENERAL.—The Medicare For All Pro-
7 gram, through its regional offices, shall pay each in-
8 stitutional provider of care, including hospitals,
9 nursing homes, community or migrant health cen-
10 ters, home care agencies, or other institutional pro-
11 viders or pre-paid group practices, a monthly lump
12 sum to cover all operating expenses under a global
13 budget.

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

23 (b) THREE PAYMENT OPTIONS FOR PHYSICIANS AND
24 CERTAIN OTHER HEALTH PROFESSIONALS.—

1 (1) IN GENERAL.—The Program shall pay phy-
2 sicians, dentists, doctors of osteopathy, pharmacists,
3 psychologists, chiropractors, doctors of optometry,
4 nurse practitioners, nurse midwives, physicians' as-
5 sistants, and other advanced practice clinicians as li-
6 censed and regulated by the States by the following
7 payment methods:
8 (A) Fee for service payment under para-
9 graph (2).
10 (B) Salaried positions in institutions re-
11 ceiving global budgets under paragraph (3).
12 (C) Salaried positions within group prac-
13 tices or non-profit health maintenance organiza-
14 tions receiving capitation payments under para-
15 graph (4).
16 (2) FEE FOR SERVICE.—
17 (A) IN GENERAL.—The Program shall ne-
18 gotiate a simplified fee schedule that is fair and
19 optimal with representatives of physicians and
20 other clinicians, after close consultation with
21 the National Board of Universal Quality and
22 Access and regional and State directors. Ini-
23 tially, the current prevailing fees or reimburse-
24 ment would be the basis for the fee negotiation

1 for all professional services covered under this
2 Act.
3 (B) CONSIDERATIONS.—In establishing
4 such schedule, the Director shall take into con-
5 sideration the following:
6 (i) The need for a uniform national
7 standard.
8 (ii) The goal of ensuring that physi-
9 cians, clinicians, pharmacists, and other
10 medical professionals be compensated at a
11 rate which reflects their expertise and the
12 value of their services, regardless of geo-
13 graphic region and past fee schedules.
14 (C) STATE PHYSICIAN PRACTICE REVIEW
15 BOARDS.—The State director for each State, in
16 consultation with representatives of the physi-
17 cian community of that State, shall establish
18 and appoint a physician practice review board
19 to assure quality, cost effectiveness, and fair re-
20 imbursements for physician delivered services.
21 (D) FINAL GUIDELINES.—The Director
22 shall be responsible for promulgating final
23 guidelines to all providers.
24 (E) BILLING.—Under this Act physicians
25 shall submit bills to the regional director on a

1 simple form, or via computer. Interest shall be
2 paid to providers who are not reimbursed within
3 30 days of submission.
4 (F) NO BALANCE BILLING.—Licensed
5 health care clinicians who accept any payment
6 from the Medicare For All Program may not
7 bill any patient for any covered service.
8 (G) UNIFORM COMPUTER ELECTRONIC
9 BILLING SYSTEM.—The Director shall create a
10 uniform computerized electronic billing system,
11 including those areas of the United States
12 where electronic billing is not yet established.
13 (3) SALARIES WITHIN INSTITUTIONS RECEIVING
14 GLOBAL BUDGETS.—
15 (A) IN GENERAL.—In the case of an insti-
16 tution, such as a hospital, health center, group
17 practice, community and migrant health center,
18 or a home care agency that elects to be paid a
19 monthly global budget for the delivery of health
20 care as well as for education and prevention
21 programs, physicians and other clinicians em-
22 ployed by such institutions shall be reimbursed
23 through a salary included as part of such a
24 budget.

1 (B) SALARY RANGES.—Salary ranges for
2 health care providers shall be determined in the
3 same way as fee schedules under paragraph (2).
4 (4) SALARIES WITHIN CAPITATED GROUPS.—
5 (A) IN GENERAL.—Health maintenance or-
6 ganizations, group practices, and other institu-
7 tions may elect to be paid capitation payments
8 to cover all outpatient, physician, and medical
9 home care provided to individuals enrolled to
10 receive benefits through the organization or en-
11 tity.
12 (B) SCOPE.—Such capitation may include
13 the costs of services of licensed physicians and
14 other licensed, independent practitioners pro-
15 vided to inpatients. Other costs of inpatient and
16 institutional care shall be excluded from capita-
17 tion payments, and shall be covered under insti-
18 tutions' global budgets.
19 (C) PROHIBITION OF SELECTIVE ENROLL-
20 MENT.—Patients shall be permitted to enroll or
21 disenroll from such organizations or entities
22 without discrimination and with appropriate no-
23 tice.
24 (D) HEALTH MAINTENANCE ORGANIZA-
25 TIONS.—Under this Act—

1 (i) health maintenance organizations
2 shall be required to reimburse physicians
3 based on a salary; and
4 (ii) financial incentives between such
5 organizations and physicians based on uti-
6 lization are prohibited.

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

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

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

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

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

1 **SEC. 204. MENTAL HEALTH SERVICES.**

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

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

15 **SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS,**
16 **MEDICAL SUPPLIES, AND MEDICALLY NEC-**
17 **ESSARY ASSISTIVE EQUIPMENT.**

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

22 (b) PRESCRIPTION DRUG FORMULARY.—

23 (1) IN GENERAL.—The Program shall establish
24 a prescription drug formulary system, which shall
25 encourage best-practices in prescribing and discour-
26 age the use of ineffective, dangerous, or excessively

1 costly medications when better alternatives are avail-
2 able.
3 (2) PROMOTION OF USE OF GENERICS.—The
4 formulary shall promote the use of generic medica-
5 tions but allow the use of brand-name and off-for-
6 mulary medications.
7 (3) FORMULARY UPDATES AND PETITION
8 RIGHTS.—The formulary shall be updated frequently
9 and clinicians and patients may petition their region
10 or the Director to add new pharmaceuticals or to re-
11 move ineffective or dangerous medications from the
12 formulary.

13 **SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSE-**
14 **MENT LEVELS.**

15 Reimbursement levels under this subtitle shall be set
16 after close consultation with regional and State Directors
17 and after the annual meeting of National Board of Uni-
18 versal Quality and Access.

19 **Subtitle B—Funding**

20 **SEC. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL**
21 **PROGRAM.**

22 (a) IN GENERAL.—The Medicare For All Program
23 is to be funded as provided in subsection (c)(1).
24 (b) MEDICARE FOR ALL TRUST FUND.—There shall
25 be established a Medicare For All Trust Fund in which

1 funds provided under this section are deposited and from
2 which expenditures under this Act are made.
3 (c) FUNDING.—
4 (1) IN GENERAL.—There are appropriated to
5 the Medicare For All Trust Fund amounts sufficient
6 to carry out this Act from the following sources:
7 (A) Existing sources of Federal Govern-
8 ment revenues for health care.
9 (B) Increasing personal income taxes on
10 the top 5 percent income earners.
11 (C) Instituting a modest and progressive
12 excise tax on payroll and self-employment in-
13 come.
14 (D) Instituting a modest tax on unearned
15 income.
16 (E) Instituting a small tax on stock and
17 bond transactions.
18 (2) SYSTEM SAVINGS AS A SOURCE OF FINANC-
19 ING.—Funding otherwise required for the Program
20 is reduced as a result of—
21 (A) vastly reducing paperwork;
22 (B) requiring a rational bulk procurement
23 of medications under section 205(a); and
24 (C) improved access to preventive health
25 care.

1 (3) ADDITIONAL ANNUAL APPROPRIATIONS TO
2 MEDICARE FOR ALL PROGRAM.—Additional sums are
3 authorized to be appropriated annually as needed to
4 maintain maximum quality, efficiency, and access
5 under the Program.

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

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

17 # TITLE III—ADMINISTRATION

18 **SEC. 301. PUBLIC ADMINISTRATION; APPOINTMENT OF DI-**
19 **RECTOR.**

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

23 (b) LONG-TERM CARE.—The Director shall appoint
24 a director for long-term care who shall be responsible for

1 administration of this Act and ensuring the availability
2 and accessibility of high quality long-term care services.
3 (c) MENTAL HEALTH.—The Director shall appoint a
4 director for mental health who shall be responsible for ad-
5 ministration of this Act and ensuring the availability and
6 accessibility of high quality mental health services.

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

8 The Director shall appoint a director for an Office
9 of Quality Control. Such director shall, after consultation
10 with State and regional directors, provide annual rec-
11 ommendations to Congress, the President, the Secretary,
12 and other Program officials on how to ensure the highest
13 quality health care service delivery. The director of the Of-
14 fice of Quality Control shall conduct an annual review on
15 the adequacy of medically necessary services, and shall
16 make recommendations of any proposed changes to the
17 Congress, the President, the Secretary, and other Medi-
18 care For All Program officials.

19 **SEC. 303. REGIONAL AND STATE ADMINISTRATION; EM-**
20 **PLOYMENT OF DISPLACED CLERICAL WORK-**
21 **ERS.**

22 (a) ESTABLISHMENT OF MEDICARE FOR ALL PRO-
23 GRAM REGIONAL OFFICES.—The Secretary shall establish
24 and maintain Medicare For All regional offices for the
25 purpose of distributing funds to providers of care. When-

1 ever possible, the Secretary should incorporate pre-exist-
2 ing Medicare infrastructure for this purpose.
3 (b) APPOINTMENT OF REGIONAL AND STATE DIREC-
4 TORS.—In each such regional office there shall be—
5 (1) one regional director appointed by the Di-
6 rector; and
7 (2) for each State in the region, a deputy direc-
8 tor (in this Act referred to as a "State Director")
9 appointed by the governor of that State.
10 (c) REGIONAL OFFICE DUTIES.—Regional offices of
11 the Program shall be responsible for—
12 (1) coordinating funding to health care pro-
13 viders and physicians; and
14 (2) coordinating billing and reimbursements
15 with physicians and health care providers through a
16 State-based reimbursement system.
17 (d) STATE DIRECTOR'S DUTIES.—Each State Direc-
18 tor shall be responsible for the following duties:
19 (1) Providing an annual State health care needs
20 assessment report to the National Board of Uni-
21 versal Quality and Access, and the regional board,
22 after a thorough examination of health needs, in
23 consultation with public health officials, clinicians,
24 patients, and patient advocates.

1 (2) Health planning, including oversight of the
2 placement of new hospitals, clinics, and other health
3 care delivery facilities.
4 (3) Health planning, including oversight of the
5 purchase and placement of new health equipment to
6 ensure timely access to care and to avoid duplica-
7 tion.
8 (4) Submitting global budgets to the regional
9 director.
10 (5) Recommending changes in provider reim-
11 bursement or payment for delivery of health services
12 in the State.
13 (6) Establishing a quality assurance mechanism
14 in the State in order to minimize both under utiliza-
15 tion and over utilization and to assure that all pro-
16 viders meet high quality standards.
17 (7) Reviewing program disbursements on a
18 quarterly basis and recommending needed adjust-
19 ments in fee schedules needed to achieve budgetary
20 targets and assure adequate access to needed care.
21 (e) FIRST PRIORITY IN RETRAINING AND JOB
22 PLACEMENT; 2 YEARS OF SALARY PARITY BENEFITS.—
23 The Program shall provide that clerical, administrative,
24 and billing personnel in insurance companies, doctors of-

1 fices, hospitals, nursing facilities, and other facilities
2 whose jobs are eliminated due to reduced administration—
3 (1) should have first priority in retraining and
4 job placement in the new system; and
5 (2) shall be eligible to receive two years of
6 Medicare For All employment transition benefits
7 with each year's benefit equal to salary earned dur-
8 ing the last 12 months of employment, but shall not
9 exceed $100,000 per year.
10 (f) ESTABLISHMENT OF MEDICARE FOR ALL EM-
11 PLOYMENT TRANSITION FUND.—The Secretary shall es-
12 tablish a trust fund from which expenditures shall be
13 made to recipients of the benefits allocated in subsection
14 (e).
15 (g) ANNUAL APPROPRIATIONS TO MEDICARE FOR
16 ALL EMPLOYMENT TRANSITION FUND.—Sums are au-
17 thorized to be appropriated annually as needed to fund
18 the Medicare For All Employment Transition Benefits.
19 (h) RETENTION OF RIGHT TO UNEMPLOYMENT BEN-
20 EFITS.—Nothing in this section shall be interpreted as a
21 waiver of Medicare For All Employment Transition ben-
22 efit recipients' right to receive Federal and State unem-
23 ployment benefits.

1 **SEC. 304. CONFIDENTIAL ELECTRONIC PATIENT RECORD**
2 **SYSTEM.**

3 (a) IN GENERAL.—The Secretary shall create a
4 standardized, confidential electronic patient record system
5 in accordance with laws and regulations to maintain accu-
6 rate patient records and to simplify the billing process,
7 thereby reducing medical errors and bureaucracy.

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

12 **SEC. 305. NATIONAL BOARD OF UNIVERSAL QUALITY AND**
13 **ACCESS.**

14 (a) ESTABLISHMENT.—

15 (1) IN GENERAL.—There is established a Na-
16 tional Board of Universal Quality and Access (in
17 this section referred to as the "Board") consisting
18 of 15 members appointed by the President, by and
19 with the advice and consent of the Senate.

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

23 (A) Health care professionals.

24 (B) Representatives of institutional pro-
25 viders of health care.

1 (C) Representatives of health care advo-
2 cacy groups.
3 (D) Representatives of labor unions.
4 (E) Citizen patient advocates.
5 (3) TERMS.—Each member shall be appointed
6 for a term of 6 years, except that the President shall
7 stagger the terms of members initially appointed so
8 that the term of no more than 3 members expires
9 in any year.
10 (4) PROHIBITION ON CONFLICTS OF INTER-
11 EST.—No member of the Board shall have a finan-
12 cial conflict of interest with the duties before the
13 Board.
14 (b) DUTIES.—
15 (1) IN GENERAL.—The Board shall meet at
16 least twice per year and shall advise the Secretary
17 and the Director on a regular basis to ensure qual-
18 ity, access, and affordability.
19 (2) SPECIFIC ISSUES.—The Board shall specifi-
20 cally address the following issues:
21 (A) Access to care.
22 (B) Quality improvement.
23 (C) Efficiency of administration.
24 (D) Adequacy of budget and funding.

1 (E) Appropriateness of reimbursement lev-
2 els of physicians and other providers.
3 (F) Capital expenditure needs.
4 (G) Long-term care.
5 (H) Mental health and substance abuse
6 services.
7 (I) Staffing levels and working conditions
8 in health care delivery facilities.
9 (3) ESTABLISHMENT OF UNIVERSAL, BEST
10 QUALITY STANDARD OF CARE.—The Board shall
11 specifically establish a universal, best quality of
12 standard of care with respect to—
13 (A) appropriate staffing levels;
14 (B) appropriate medical technology;
15 (C) design and scope of work in the health
16 workplace;
17 (D) best practices; and
18 (E) salary level and working conditions of
19 physicians, clinicians, nurses, other medical pro-
20 fessionals, and appropriate support staff.
21 (4) TWICE-A-YEAR REPORT.—The Board shall
22 report its recommendations twice each year to the
23 Secretary, the Director, Congress, and the Presi-
24 dent.

1 (c) COMPENSATION, ETC.—The following provisions
2 of section 1805 of the Social Security Act shall apply to
3 the Board in the same manner as they apply to the Medi-
4 care Payment Assessment Commission (except that any
5 reference to the Commission or the Comptroller General
6 shall be treated as references to the Board and the Sec-
7 retary, respectively):
8 (1) Subsection (c)(4) (relating to compensation
9 of Board members).
10 (2) Subsection (c)(5) (relating to chairman and
11 vice chairman).
12 (3) Subsection (c)(6) (relating to meetings).
13 (4) Subsection (d) (relating to director and
14 staff; experts and consultants).
15 (5) Subsection (e) (relating to powers).

16 # TITLE IV—ADDITIONAL
17 # PROVISIONS

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

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

1 pendent or be integrated into the Medicare For All Pro-
2 gram.

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

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

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

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

14 It is the intent of this Act to reduce health disparities
15 by race, ethnicity, income and geographic region, and to
16 provide high quality, cost-effective, culturally appropriate
17 care to all individuals regardless of race, ethnicity, sexual
18 orientation, or language.

19 # TITLE V—EFFECTIVE DATE

20 **SEC. 501. EFFECTIVE DATE.**

21 Except as otherwise specifically provided, this Act
22 shall take effect on the first day of the first year that be-
23 gins more than 1 year after the date of the enactment
24 of this Act, and shall apply to items and services furnished
25 on or after such date.