

109TH CONGRESS
1ST SESSION

H. R. 676

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

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2005

Mr. CONYERS (for himself, Mr. KUCINICH, Mr. McDERMOTT, and Mrs. CHRISTENSEN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Resources, and Veterans' Affairs, 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, 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 “United States National Health Insurance Act (or the Ex-
6 panded and Improved Medicare for All Act)”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 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 USNHI Program.
 Sec. 212. Appropriations for existing programs for uninsured and indigent.

TITLE III—ADMINISTRATION

- Sec. 301. Public administration; appointment of Director.
 Sec. 302. Quality and cost 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) **USNHI PROGRAM; PROGRAM.**—The terms
 4 “USNHI Program” and “Program” mean the pro-
 5 gram of benefits provided under this Act and, unless
 6 the context otherwise requires, the Secretary with

1 respect to functions relating to carrying out such
2 program.

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

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

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

12 (5) DIRECTOR.—The term “Director” means,
13 in relation to the Program, the Director appointed
14 under section 301.

15 **TITLE I—ELIGIBILITY AND** 16 **BENEFITS**

17 **SEC. 101. ELIGIBILITY AND REGISTRATION.**

18 (a) IN GENERAL.—All individuals residing in the
19 United States (including any territory of the United
20 States) are covered under the USNHI Program entitling
21 them to a universal, best quality standard of care. Each
22 such individual shall receive a card with a unique number
23 in the mail. An individual’s social security number shall
24 not be used for purposes of registration under this section.

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

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

13 **SEC. 102. BENEFITS AND PORTABILITY.**

14 (a) IN GENERAL.—The health insurance benefits
15 under this Act cover all medically necessary services, in-
16 cluding—

- 17 (1) primary care and prevention;
- 18 (2) inpatient care;
- 19 (3) outpatient care;
- 20 (4) emergency care;
- 21 (5) prescription drugs;
- 22 (6) durable medical equipment;
- 23 (7) long term care;
- 24 (8) mental health services;

1 (9) the full scope of dental services (other than
2 cosmetic dentistry);

3 (10) substance abuse treatment services;

4 (11) chiropractic services; and

5 (12) basic vision care and vision correction
6 (other than laser vision correction for cosmetic pur-
7 poses).

8 (b) PORTABILITY.—Such benefits are available
9 through any licensed health care clinician anywhere in the
10 United States that is legally qualified to provide the bene-
11 fits.

12 (c) NO COST-SHARING.—No deductibles, copayments,
13 coinsurance, or other cost-sharing shall be imposed with
14 respect to covered benefits.

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

16 (a) REQUIREMENT TO BE PUBLIC OR NON-PROF-
17 IT.—

18 (1) IN GENERAL.—No institution may be a par-
19 ticipating provider unless it is a public or not-for-
20 profit institution.

21 (2) CONVERSION OF INVESTOR-OWNED PRO-
22 VIDERS.—Investor-owned providers of care opting to
23 participate shall be required to convert to not-for-
24 profit status.

1 (3) COMPENSATION FOR CONVERSION.—The
2 owners of such investor-owned providers shall be
3 compensated for the actual appraised value of con-
4 verted facilities used in the delivery of care.

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

9 (5) REQUIREMENTS.—The conversion to a not-
10 for-profit health care system shall take place over a
11 15-year period, through the sale of US Treasury
12 Bonds. Payment for conversions under paragraph
13 (3) shall not be made for loss of business profits,
14 but may be made only for costs associated with the
15 conversion of real property and equipment.

16 (b) QUALITY STANDARDS.—

17 (1) IN GENERAL.—Health care delivery facili-
18 ties must meet regional and State quality and licens-
19 ing guidelines as a condition of participation under
20 such program, including guidelines regarding safe
21 staffing and quality of care.

22 (2) LICENSURE REQUIREMENTS.—Participating
23 clinicians must be licensed in their State of practice
24 and meet the quality standards for their area of
25 care. No clinician whose license is under suspension

1 or who is under disciplinary action in any State may
2 be a participating provider.

3 (c) PARTICIPATION OF HEALTH MAINTENANCE OR-
4 GANIZATIONS.—

5 (1) IN GENERAL.—Non-profit health mainte-
6 nance organizations that actually deliver care in
7 their own facilities and employ clinicians on a sala-
8 ried basis may participate in the program and re-
9 ceive global budgets or capitation payments as speci-
10 fied in section 202.

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

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

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

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

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

10 **TITLE II—FINANCES**
11 **Subtitle A—Budgeting and**
12 **Payments**

13 **SEC. 201. BUDGETING PROCESS.**

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

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

19 (A) an operating budget;

20 (B) a capital expenditures budget;

21 (C) reimbursement levels for providers con-
22 sistent with subtitle B; and

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

1 (2) REGIONAL ALLOCATION.—After Congress
2 appropriates amounts for the annual budget for the
3 USNHI Program, the Director shall provide the re-
4 gional offices with an annual funding allotment to
5 cover the costs of each region’s expenditures. Such
6 allotment shall cover global budgets, reimbursements
7 to clinicians, and capital expenditures. Regional of-
8 fices may receive additional funds from the national
9 program at the discretion of the Director.

10 (b) OPERATING BUDGET.—The operating budget
11 shall be used for—

12 (1) payment for services rendered by physicians
13 and other clinicians;

14 (2) global budgets for institutional providers;

15 (3) capitation payments for capitated groups;

16 and

17 (4) administration of the Program.

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

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

22 (2) for major equipment purchases.

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

1 (1) for operations for capital expenditures; or

2 (2) for capital expenditures for operations.

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

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

7 (1) IN GENERAL.—The USNHI Program,
8 through its regional offices, shall pay each hospital,
9 nursing home, community or migrant health center,
10 home care agencies, or other institutional provider
11 or pre-paid group practice a monthly lump sum to
12 cover all operating expenses under a global budget.

13 (2) ESTABLISHMENT OF GLOBAL BUDGETS.—
14 The global budget of a provider shall be set through
15 negotiations between providers and regional direc-
16 tors, but are subject to the approval of the Director.
17 The budget shall be negotiated annually, based on
18 past expenditures, projected changes in levels of
19 services, wages and input, costs, and proposed new
20 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, psycholo-
25 gists, chiropractors, doctors of optometry, nurse

1 practitioners, nurse midwives, physicians' assistants,
2 and other advanced practice clinicians as licensed
3 and regulated by the States by the following pay-
4 ment methods:

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

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

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

13 (2) FEE FOR SERVICE.—

14 (A) IN GENERAL.—The Program shall ne-
15 gotiate a simplified fee schedule that is fair
16 with representatives of physicians and other cli-
17 nicians, after close consultation with the Na-
18 tional Board of Universal Quality and Access
19 and regional and State directors. Initially, the
20 current prevailing fees or reimbursement would
21 be the basis for the fee negotiation for all pro-
22 fessional services covered under this Act.

23 (B) CONSIDERATIONS.—In establishing
24 such schedule, the Director shall take into con-
25 sideration regional differences in reimburse-

1 ment, but strive for a uniform national stand-
2 ard.

3 (C) STATE PHYSICIAN PRACTICE REVIEW
4 BOARDS.— The State director for each State, in
5 consultation with representatives of the physi-
6 cian community of that State, shall establish
7 and appoint a physician practice review board
8 to assure quality, cost effectiveness, and fair re-
9 imbursements for physician delivered services.

10 (D) FINAL GUIDELINES.—The regional di-
11 rectors shall be responsible for promulgating
12 final guidelines to all providers.

13 (E) BILLING.—Under this Act physicians
14 shall submit bills to the regional director on a
15 simple form, or via computer. Interest shall be
16 paid to providers whose bills are not paid within
17 30 days of submission.

18 (F) NO BALANCE BILLING.—Licensed
19 health care clinicians who accept any payment
20 from the USNHI Program may not bill any pa-
21 tient for any covered service.

22 (G) UNIFORM COMPUTER ELECTRONIC
23 BILLING SYSTEM.—The Director shall make a
24 good faith effort to create a uniform computer-
25 ized electronic billing system, including in those

1 areas of the United States where electronic bill-
2 ing is not yet established.

3 (3) SALARIES WITHIN INSTITUTIONS RECEIVING
4 GLOBAL BUDGETS.—

5 (A) IN GENERAL.—In the case of an insti-
6 tution, such as a hospital, health center, group
7 practice, community and migrant health center,
8 or a home care agency that elects to be paid a
9 monthly global budget for the delivery of health
10 care as well as for education and prevention
11 programs, physicians employed by such institu-
12 tions shall be reimbursed through a salary in-
13 cluded as part of such a budget.

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

17 (4) SALARIES WITHIN CAPITATED GROUPS.—

18 (A) IN GENERAL.—Health maintenance or-
19 ganizations, group practices, and other institu-
20 tions may elect to be paid capitation premiums
21 to cover all outpatient, physician, and medical
22 home care provided to individuals enrolled to
23 receive benefits through the organization or en-
24 tity.

1 (B) SCOPE.—Such capitation may include
2 the costs of services of licensed physicians and
3 other licensed, independent practitioners pro-
4 vided to inpatients. Other costs of inpatient and
5 institutional care shall be excluded from capita-
6 tion payments, and shall be covered under insti-
7 tutions’ global budgets.

8 (C) PROHIBITION OF SELECTIVE ENROLL-
9 MENT.—Selective enrollment policies are pro-
10 hibited, and patients shall be permitted to en-
11 roll or disenroll from such organizations or enti-
12 ties with appropriate notice.

13 (D) HEALTH MAINTENANCE ORGANIZA-
14 TIONS.—Under this Act—

15 (i) health maintenance organizations
16 shall be required to reimburse physicians
17 based on a salary; and

18 (ii) financial incentives between such
19 organizations and physicians based on uti-
20 lization are prohibited.

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

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

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

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

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

14 **SEC. 204. MENTAL HEALTH SERVICES.**

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

21 (b) FAVORING COMMUNITY-BASED CARE.—The
22 USNHI Program shall cover supportive residences, occu-
23 pational therapy, and ongoing mental health and coun-
24 seling services outside the hospital for patients with seri-
25 ous mental illness. In all cases the highest quality and

1 most effective care shall be delivered, and, for some indi-
2 viduals, this may mean institutional care.

3 **SEC. 205. PAYMENT FOR PRESCRIPTION MEDICATIONS,**
4 **MEDICAL SUPPLIES, AND MEDICALLY NEC-**
5 **CESSARY ASSISTIVE EQUIPMENT.**

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

10 (b) **PRESCRIPTION DRUG FORMULARY.**—

11 (1) **IN GENERAL.**—The Program shall establish
12 a prescription drug formulary system, which shall
13 encourage best-practices in prescribing and discour-
14 age the use of ineffective, dangerous, or excessively
15 costly medications when better alternatives are avail-
16 able.

17 (2) **PROMOTION OF USE OF GENERICS.**—The
18 formulary shall promote the use of generic medica-
19 tions but allow the use of brand-name and off-for-
20 mulary medications when indicated for a specific pa-
21 tient or condition.

22 (3) **FORMULARY UPDATES AND PETITION**
23 **RIGHTS.**—The formulary shall be updated frequently
24 and clinicians and patients may petition their region
25 or the Director to add new pharmaceuticals or to re-

1 move ineffective or dangerous medications from the
2 formulary.

3 **SEC. 206. CONSULTATION IN ESTABLISHING REIMBURSE-**
4 **MENT LEVELS.**

5 Reimbursement levels under this subtitle shall be set
6 after close consultation with regional and State Directors
7 and after the annual meeting of National Board of Uni-
8 versal Quality and Access.

9 **Subtitle B—Funding**

10 **SEC. 211. OVERVIEW: FUNDING THE USNHI PROGRAM.**

11 (a) IN GENERAL.—The USNHI Program is to be
12 funded as provided in subsections (b) and (c).

13 (b) ANNUAL APPROPRIATION FOR FUNDING OF
14 USNHI PROGRAM.—There are authorized to be appro-
15 priated to carry out this Act such sums as may be nec-
16 essary.

17 (c) INTENT.—Sums appropriated pursuant to sub-
18 section (b) shall be paid for—

19 (1) by vastly reducing paperwork;

20 (2) by requiring a rational bulk procurement of
21 medications;

22 (3) from existing sources of Federal govern-
23 ment revenues for health care;

24 (4) by increasing personal income taxes on the
25 top 5 percent income earners;

1 (5) by instituting a modest payroll tax; and
2 (6) by instituting a small tax on stock and bond
3 transactions.

4 **SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS FOR**
5 **UNINSURED AND INDIGENT.**

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

16 **TITLE III—ADMINISTRATION**

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

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

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

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

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

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

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

20 (a) USE OF REGIONAL OFFICES.—The Program
21 shall establish and maintain regional offices. Such regional
22 offices shall replace all regional Medicare offices.

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

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

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

6 (c) REGIONAL OFFICE DUTIES.—

7 (1) IN GENERAL.—Regional offices of the Pro-
8 gram shall be responsible for—

9 (A) coordinating funding to health care
10 providers and physicians; and

11 (B) coordinating billing and reimburse-
12 ments with physicians and health care providers
13 through a State-based reimbursement system.

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

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

22 (2) Health planning, including oversight of the
23 placement of new hospitals, clinics, and other health
24 care delivery facilities.

1 (3) Health planning, including oversight of the
2 purchase and placement of new health equipment to
3 ensure timely access to care and to avoid dupli-
4 cation.

5 (4) Submitting global budgets to the regional
6 director.

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

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

14 (7) Reviewing program disbursements on a
15 quarterly basis and recommending needed adjust-
16 ments in fee schedules needed to achieve budgetary
17 targets and assure adequate access to needed care.

18 (e) **FIRST PRIORITY IN RETRAINING AND JOB**
19 **PLACEMENT.**—The Program shall provide that clerical
20 and administrative workers in insurance companies, doc-
21 tors offices, hospitals, nursing facilities and other facilities
22 whose jobs are eliminated due to reduced administration,
23 should have first priority in retraining and job placement
24 in the new system.

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; and

17 (D) best practices.

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

22 (c) COMPENSATION, ETC.—The following provisions
23 of section 1805 of the Social Security Act shall apply to
24 the Board in the same manner as they apply to the Medi-
25 care Payment Assessment Commission (except that any

1 reference to the Commission or the Comptroller General
2 shall be treated as references to the Board and the Sec-
3 retary, respectively):

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

6 (2) Subsection (c)(5) (relating to chairman and
7 vice chairman)

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

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

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

12 **TITLE IV—ADDITIONAL** 13 **PROVISIONS**

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

15 This Act provides for health programs of the Depart-
16 ment of Veterans' Affairs and of the Indian Health Serv-
17 ice to initially remain independent for the 5-year period
18 that begins on the date of the establishment of the
19 USNHI program, but after such period those programs
20 shall be integrated into the USNHI program.

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

22 It is the intent of this Act that the Program at all
23 times stress the importance of good public health through
24 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 January 1, 2007, and shall apply to
11 items and services furnished on or after such date.

○