

A Bill for

Rational Healthcare Reform

Version 2.02

Physicians for Rational HealthCare Reform

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XXXth Congress

1st Session

To provide comprehensive health care coverage for all United States Residents and Visitors.

In the House of Representatives

Date XXXX

Sponsors: Physicians for Rational HealthCare Reform

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

It is the intent of this bill to utilize the existing private provider basis of the current healthcare delivery system, reimbursing on a work-based fee-for-service basis, or as otherwise specified in this bill, where at all possible.

There is nothing in this bill that restricts provider choice or inhibits provider-provider competition.

This Program shall be available to all Americans and visitors.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

Sec.1. Short Title; Table of Contents

- (a) Short Title- This Act may be cited as the United States National Health Program Act (USNHP) (or Enhanced Medicare Program for All Act).
- (b) Table of Contents- The table of this Act is as follows:
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Sec.2. Definitions and Terms

In this Act:

- (1) USNHP; The Program- The terms ‘United States National Health Program’, abbreviated ‘USNHP’, and “The Program” means the program of benefits provided under this Act.
- (2) National Board of Health Care- The term ‘National Board of Health Care’ means such Board established under Sec.409. This Board may be abbreviated ‘NBHC’.
- (3) Regional Office- The term ‘Regional Office’ means a regional office established under Sec.406.
- (4) Secretary- The term ‘Secretary’ means the Secretary of Health and Human Services.
- (5) Director General- The term ‘Director General’ means, in relation to the Program, the Director appointed under Sec.401.

Title I—General Structure and Approach

Sec.101. Medicare as a Starting Point

- (a) In General- The current Medicare system represents universal healthcare for those 65 years and older. Medicare and its infrastructure will be modified as follows.
 - (1) Start with the basic Medicare plan as it exists today.
 - (2) Issue a unique ID number (not a Social Security Number) to each current Medicare enrollee.
 - (3) Discontinue the annual deductible payment requirement as it exists today.
 - (4) Include drug coverage as discussed below.
 - (5) Restructure the “Point of Service” co-payment as discussed below.
 - (6) Dissolve the “Medicare Advantage” plans and re-enroll those people back into Medicare as modified.
 - (7) Eliminate the current Medicare “Supplement” system and modify the Medicare health care offerings as discussed below.
 - (8) In the place of the monies paid into the current private supplement system and those monies used to support the ‘Medicare Advantage’ plans, each enrollee will be assigned a means adjusted monthly premium to be paid directly into Medicare, and the monies currently used to support the Advantage plans will be paid directly into the Program.
 - (9) Re-evaluate the required infrastructure and enhance as needed, at each step.
- (b) As Monies and Infrastructure Allow, Expand to Include-
 - (1) Enroll all people ages 1 through 17 years old and pregnant women up to two years post partum.
 - (2) Issue the appropriate ID number to each.
 - (3) Channel all monies currently being spent on these groups into The Program/Medicare system as modified above.
 - (4) Re-evaluate the required infrastructure and enhance as needed.
- (c) As Monies and Infrastructure Allow, offer this Program to all by working backward through the remaining un-enrolled age groups in 5-year increments. Persons in the 18-64 year old age groups can elect to continue, their current insurance product as long as that product adheres to the intent and services of this program.
 - (1) Starting with ages 60 through 64 years old, then 55 through 59 years old, and continue until all age groups are enrolled.
 - (2) After each 5-year age block is enrolled, re-evaluate the monies and infrastructure and enhance as needed, before further proceeding.
 - (3) As each 5-year age block is enrolled, channel those monies and standardized monthly premiums into Medicare as modified above.

- (4) As each 5-year age block is enrolled, the current private health insurance plans may continue to be offered, as provided for below, if they are still desired as and option.
- (d) Begin issuing temporary USNHP ID numbers to foreign citizen tourists and visitors and place this number on their visa card, or similar location. This number would be valid for a defined period of time.
- (e) Look for groups of people not included in standard populations above, and therefore not yet enrolled in The Program. Examples:
 - (1) Homeless persons- devise a Point of Service registration system, and tracking mechanism as possible.
 - (2) Illegal Aliens- same as (1) above.
 - (3) Persons afraid of “government surveillance”- devise a modified ID system to allow them to participate.

Sec.102. Expanding Past the Current Medicare Benefits Profile

Medicare as it currently exists does not offer full benefits. As the opportunity, monies, and infrastructure allow, expand coverage as possible. As example, dental and ocular services above basic and corrective could be phased in as funding allows.

Sec.103. Citizen/Patient Financial Contributions to the Program

Given the cost of a universal healthcare system, the state of the National Debt, and the complexity of our Federal Income Tax System, it will be necessary for the general population of the United States and its Territories to contribute financially to this Program. See Subtitle B.

Title II—Eligibility and Benefits

Sec.201. Eligibility and Registration

- (a) In General- All individuals residing in the United States (including any territory of the United States) are covered under the USNHP entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number after his or her registration with the program. It may be delivered by mail or by other means as may be established by the Director General. This number shall not be a person’s social security number.
- (b) Registration- Individual and families shall receive a USNHP identification card in the mail, or other suitable method as determined by the Director General, after filling out a USNHP application form obtained from a health care provider, or other suitable site as designated by the Board. This form shall be of minimal length and simply written.

- (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 USNHP card. For patients who present for service but refuse to register with the Program, the provider shall submit their bill for services filed on an “unregistered patient” claim form.
- (d) Additionally, legal visitors to the United States or its Territories shall be entitled to the benefits of this plan while on limited vacations or visitations. Their USNHP ID number, described below, will be issued with their visa, or by similar process as approved by the Board. Legal visitors on extended work or education programs will be expected to participate in the funding provisions outlined below in Sec.311.

Sec.202. Benefits and Portability

- (a) In General- The healthcare provided under this act shall cover medically necessary services, including the following items, as addressed.
 - 1. Primary care and prevention
 - 2. Inpatient care
 - 3. Outpatient care
 - 4. Emergency care
 - 5. Prescription drugs, as considered below
 - 6. Durable medical equipment, as considered below
 - 7. Long term care, as considered below
 - 8. Mental health services, as considered below
 - 9. Dental services, as considered below
 - 10. Substance abuse services, as considered below
 - 11. Chiropractic services, per usual timeframe limitations
 - 12. Basic vision care and vision correction
 - 13. Speech and Hearing services, including “basic model” hearing aids
- (b) Portability- Such benefits are available through any licensed health care provider anywhere in the United States who is credentialed for this program.
- (c) Individual Funding- In consideration of the current national debt of the United States and that less than sixty percent of US citizens currently pay federal income taxes, it is clear that the taxpayer cannot be asked to solely support this program. Accordingly, there will be a “means adjusted” monthly premium assigned to each citizen that will be paid directly to this Enhanced Medicare Program. This may be, in part, collected as are income tax withholdings, with a monthly payroll deduction or quarterly estimated payment. This “means adjusted” premium will apply to all, including persons retired, disabled, on welfare, self employed, and other groups. For persons receiving a subsistence check, the means adjusted premium could be withheld from it monthly. In a similar fashion, premium payments may be withheld from other sources, such as the earned-income tax credit, etc. It is understood that there will always be persons, such as transients and

the homeless and those who refuse to register, who cannot be tracked and assessed appropriately.

- (d) Employer Funding- There will be funding for the program paid by employers on a per employee basis, and paid directly into The Program, and may be separate from that employee's individual contribution.
- (e) Cost sharing- In addition to the above noted means adjusted monthly premium, there will be a point of service co-payment (means adjusted) due at the time of service. It could be paid in cash at that time, or charged back to their premium obligation, and paid back to the program at a later time. There will be limits to the number of separate co-payments paid by a given individual or family over a limited time frame, currently planned to be 4 calendar weeks.

Sec.203. Qualification of Participating Providers

(a) Requirement to be a Provider-

- (1) In General- No individual, group, or institution that generates "profit" by further restricting the number, type or quantity of medications, goods, or services delivered under this Program (past the limitations instituted by the program itself) may be a participating provide. Profit by work, as with fee-for-service, will be encouraged, whether by groups, individuals, or corporations.
- (2) Any individual, group, or provider corporation who currently bills, or plans to bill, the Program on a work based fee-for-service basis, shall be encouraged to continue as private entities.
- (3) The program will encourage provider participation as private entities and will only directly sponsor and/or employ providers either to fill underserved areas or at the request of that provider. Fees shall be comparable for either situation.
- (4) Conversion of Investor Owned Providers- Investor owned providers of care may be allowed to convert to not-for-profit status for full integration into this program, if they so chose.
- (5) Compensation for Conversion to Not-For-Profit Status- As investor owned facilities are assimilated into this Program, the investors may be compensated for the fair market value of any fixed assets that can be utilized by the Program. They will not be compensated for lost profits.
- (6) Funding for Compensation in (3) above- Payment for the above assets will be paid out over up to 10 years from the Capital Expenditures Budget. If needed, it will be authorized to periodically appropriate some funds from the Treasury in order to make these payments on a reasonable time frame. Senate approval shall be required for such appropriations.

(b) Quality Standards-

- (1) In General- Health care delivery facilities must meet both regional and state quality and licensing guidelines as a condition of participation under

this Program, including guidelines regarding safe staffing and quality of care.

- (2) Licensure Requirements- Participating clinicians must be licensed in their State of practice, though a program-wide licensing system may be implemented at a later date. Clinicians must be in good standing in their current state of practice and may not be in poor standing with any other state, US territory, or foreign country.
- (c) Participation of Health Maintenance Organizations-
 - (1) Non-Profit health maintenance organizations that deliver care in their own facilities and employ providers on a salaried basis may participate in the Program and receive global budgets of capitation payments as specified in Sec.302.
 - (2) Restriction of Certain Health Maintenance Organizations- Other health maintenance organizations, including those which principally contract to pay for services delivered by non-employees, shall be classified as insurance plans. Such organizations shall be severely limited in provider roles by reason of Sec.204 (a), (restricting duplicating coverage).
- (d) Freedom of Choice- Patients shall have freedom of choice of participating physicians and other clinicians, hospitals, inpatient care facilities, etc.
- (e) Competition- Competition between providers to improve their skills and services shall be encouraged and rewarded.

Sec.204. Prohibition against duplicating coverage

- (a) In General- It is unlawful for a private health insurer to sell health insurance coverage that includes the benefits provided under this Act, as passed or under future modification, unless that coverage meets or exceeds the coverage as it exists in the Program at any given time, with no patient or provider detriment.
- (b) Construction- Otherwise, nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this act, such as elective cosmetic services or other services and items that are not currently deemed medically necessary.
- (c) It is recognized that some individuals will not want to be registered in a plan that is tied to the Federal Government in any way. Alternate means of participation will be explored, though this may be an area to allow continued private plan coverage, if those plans adhere to the guidelines of the Program as currently in place at that time, and to no patient or provider detriment.

Title III Finances

Subtitle A—Budgeting and Payments

Sec.301. 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
 - (B) a capital expenditures budget
 - (C) a reimbursement budget for providers consistent with ‘subtitle B’ and
 - (D) a health professional education budget, including amounts for the continued funding of resident physician training programs, and continuing provider and clerical education as in Sec.505 and Sec.506.
 - (2) Regional Allocation- After Congress appropriates amounts for the annual budget for the USNHP, the Director General shall provide the regional offices with an annual funding allotment to cover the cost of each region’s expenditures. Such allotment shall cover global budgets, reimbursements to the clinicians, and capital expenditures. Regional offices may receive additional funds from the national program at the discretion of the Board.
- (b) Operating Budget- The operating budget shall be used for:
 - (1) payment for services rendered by physicians and other clinicians;
 - (2) global budgets for institutional providers;
 - (3) capitation payments for capitated groups; and
 - (4) administration of the program.
- (c) Capital Expenditures Budget- The capital expenditures budget shall be used for funds needed for—
 - (1) the construction or renovation of health facilities; and
 - (2) for major equipment purchases.
 - (3) for acquisition of Program needed private assets as outlined in Sec.203(a)(3) above.
- (d) Prohibition against Co-Mingling Operations and Capital Expenditures Funds- It is prohibited to use funds under this Act that are earmarked—
 - (1) for “operations” to be used for “capital expenditures”; or
 - (2) for “capital” expenditures to be used for “operations”.

Sec.302. Payment of Providers and Health Care Clinicians

- (a) Establishing Global Budgets; Monthly Lump Sum-
 - (1) In General- the USNHP, through it's regional offices, shall pay each hospital, nursing home, community or migrant health center, Home Care agencies, our other institutional provider or prepaid group practice, a monthly lump sum to cover all operating expenses under a global budget. Consideration of the number of patient contacts shall be required.
 - (2) Establishment of Global Budgets- the global budgets of the provider shall be set through negotiations between providers and regional and state directors, but are subject to the approval of the Director General. The budget shall be negotiated annually, based on past expenditures, projected changes in levels of service, wages, cost, and proposed new and innovative programs.
- (b) Four Payment Option for Physicians and Certain Other Health Professionals-
 - (1) In General- the program shall pay physicians, dentists, doctors of osteopathy, psychologists, chiropractors, doctors of optometry, nurse practitioners, nurse midwives, physician's assistants, and other advanced practice clinicians as licensed and regulated by the states, or as licensed and regulated by United States National Health Program as it evolves, by the following payment methods:
 - (A) Fee for service payment under paragraph (2).
 - (B) Salaried positions in institutions receiving global budgets under paragraph (3). Salaried positions shall be limited to maintain an incentive to see patients.
 - (C) Salaried positions within group practices or non-profit health maintenance organizations receiving capitation payments under paragraph (4).
 - (D) A base salary with fee for service incentive.
 - (2) Fee For Service-
 - (A) In General- the Director General shall negotiate a fair and simplified fee schedule with representatives of physicians and other clinicians, after close consultation with the National Board of HealthCare and with regional and state directors. Initially, the current prevailing fees for reimbursement would be the basis for the fee negotiations for all professional services under this act.
 - (B) Considerations- In establishing such schedule, the Director General shall take into consideration regional differences in cost of living and in reimbursement, but strive for a uniform national standard.
 - (C) State Provider Practice Review Boards- the state director for each state, in consultation with representatives of the

provider community of that state, shall establish and appoint a provider practice review board to assure quality, cost effectiveness, and fair reimbursements for providers' delivered services.

- (D) Final Guidelines- The regional directors shall be responsible for promulgating the final guidelines to all providers.
 - (E) Billing- Under this act Providers shall submit bills to the regional directors on a simple form, or via a computer. Interest shall be paid to providers whose bills are not paid within 30 days of submission. A small charge per claim may be assessed each provider who continues to bill on paper forms after allowing a suitable grace period, the length of which is to be decided by the Director General.
 - (F) No Balance Billing- Licensed healthcare clinicians who accept any payment from the United States National Health Program may not bill any patient for any covered service, except for their approved means-adjusted co-payment.
 - (G) Non-Covered Services- Any non-covered service that is provided to a patient by a provider participating in the USNHP must first have a signed waiver from the patient acknowledging that this is a non-covered service, that it is generally not medically necessary, and then listing the estimated cost to the patient as well as expected payment arrangements.
 - (H) Uniform Computer Electronic Billing System- The Director General shall cause to be created a uniform computerized electronic billing system, including for use in those areas of United States where electronic billing is not yet established. This electronic billing system shall be versatile and shall have the provision for marking certain parts of the patient's chart as private and not transferable by electronic or print medium without the patient's written permission. Additionally, there shall be no electronic access to this medical chart without the reasonable awareness of the patient, the physician, his office, or his representative.
- (3) Salaries Within Institutions Receiving Global Budgets-
- (A) In General- Health Maintenance Organizations, group practices, and other institutions may elect to be paid capitation premiums to cover all outpatient, physician, and medical homecare provided to individuals enrolled to receive benefits through the organization or entity.
 - (B) Scope- Such capitation may include the cost of services of licensed physicians and other licensed, independent practitioners provided to inpatients. Other costs of inpatient and institutional care shall be excluded from capitation

payments, but shall be covered under the institutions global budgets.

(C) Prohibition of Selective Enrollment- Selective enrollment policies are prohibited and patients shall be permitted to enroll or dis-enroll from such organizations or entities with appropriate notice.

(D) Health Maintenance Organizations- Under this Act:

(i) Health Maintenance Organizations shall be required to reimburse providers based on a salary for a defined amount of work; and

(ii) Financial incentives between such organizations and physicians based on utilization are prohibited.

(4) Base Salary Plus Fee for Service Incentive- This option is designed for providers just starting practice, those practicing in underserved or thinly populated areas, and similar situations. The incentive for them to actually attend to patients in reasonable numbers must be substantial.

Sec.303. Payment for Long Term Care

- (a) Allotment for Regions- The Program should 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. This may include a monthly payment to a family who decides to keep a patient at home, who would otherwise have be institutionalized. This will not cover expenditures for “sitters” or non-“Home Health” nursing care at this time.

Sec.304. Mental Health Services

- (a) In General- The program shall provide coverage for all medically necessary mental healthcare on the same basis as the coverage for other conditions. Licensed mental health professionals shall be paid in the same manner as specified for other health professionals, as provided for in section 302(b).
- (b) Inpatient Mental Health Care- Inpatient mental health care shall be reasonably provided under this act. It is recognized that this care can be quite protracted and expensive and it is expected that the Director General will continually

- review the data from this program, and in conjunction with input from the DMHC and the medical community, ensure a reasonable cost/benefit aspect.
- (c) Favoring Community Based Care- The United States Health Program shall cover supportive residences, occupational therapy, and on-going mental help and counseling services outside of the hospital for patients with serious mental illnesses. In all cases the highest quality and the most effective care shall be delivered, and, for some individuals, this may mean institutional care as provided for in subsection (b) above.

Sec.305. Payment for Prescription Medications, Medical Supplies, and Medically Necessary Assistive Equipment

- (a) Negotiated Prices- The price to be paid each year under this act for covered medical supplies and medically necessary assistive equipment shall be negotiated annually by the Director General.
- (b) Used Assistive Equipment- Used assistive equipment still has value after its initial use. It should be examined and refurbished as possible then re-issued as needed. The original equipment supplier may be required to aid in this effort as a condition of being allowed to sell equipment to the Program.
- (c) Prescription Medications-
- (1) In General- The program shall establish a prescription drug 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 the Use of Generics- It is recognized that there are a multitude of cost effective and medically effective generic medications. These are available to treat a wide range of diseases including, but not limited to, diabetes, hypertension, and hyperlipidemia. Accordingly, the Director General will establish a drug class payment system that will be a set amount for a generic medication no matter which drug of that class is prescribed. If the actual drug prescribed cost more than the established generic payment, then the patient will pay the difference. It is recognized that the patient will steer the provider into prescribing the most cost effective drug for their condition.
 - (3) Medically Necessary Non-Generic Medications- It is recognized that there are many medical conditions for which there are no or few cost effective generic equivalents available. It is expected that the Director General will maintain a list of these medications and negotiate annually for the lowest price available for each of them. It is suggested that the Program pay no more than the average price paid for these drugs by the rest of the world.

- (4) Formulary Updates and Petition Rights- The formulary shall be updated frequently and clinicians and patients may petition for new pharmaceuticals to be added or to remove ineffective or dangerous medications from the formulary.
- (5) Pharmaceutical Advertising- Direct to consumer pharmaceutical advertising shall be prohibited, however, the promotion of public awareness of various medical problems and remedies shall be encouraged.

Sec.306. Consultation in Establishing Reimbursement Levels

Reimbursement levels under this subtitle should be set after close consultation with regional and state directors and after the annual meeting of National Board of Health Care.

Subtitle B—Funding

Sec.311. Overview: Funding the USNHP Program

- (a) In General- The USNHP program is to be funded as provided in subsection (c)(1) below.
- (b) USNHP Trust Fund- There shall be established a United States National Health Program trust fund, in which the funds provided under this section are deposited and from which the expenditures under this act are made.
- (c) Funding-
 - (1) In General- there are to be appropriated to the USNHP trust fund amounts sufficient to carry out this act, from the following sources:
 - (A) Existing Federal government revenues for health care will be utilized.
 - (B) A monthly premium assessed to individuals or to families that will be paid directly into the program in a mechanism similar to that used for income tax payments. This premium is to be adjusted for an individual's or family's means to pay, but everyone is to be assessed something. This premium may be age adjusted and independent of uncontrollable risk factors, but may be adjusted for controllable risk factors.
 - (C) Utilization of a "means adjusted" co-payment system payable at the time of service as discussed in Sec. 202(e) above
 - (D) Employers will be assessed an amount for each employee that will be paid directly into the program. This amount might be company "means adjusted" within reason. This may be separate from the employee's individual premium.
 - (2) Expected Systems Savings by Reduction of the Current Expenses Include-

- (i) Reduction in Medication Expenses
 - (ii) Reduction in fraud and abuse of the system that will be possible due to the utilization of a single information system.
 - (iii) Reform of the Current “for profit” system and capture of those monies for this program.
 - (iv) Preventive care savings.
 - (v) Reduction in over utilization.
 - (vi) Elimination of the massive redundancies that exist between the current agencies, companies, and plans.
 - (vii) Capture of the monies now spent on individual health plan advertising and promotions.
 - (viii) Savings in medical legal fees and malpractice insurance payments. (Sec.504.)
 - (ix) Savings resulting from the use of standardized continuing medical education and dissemination of information regarding detection and correction of medical errors and bad outcomes analysis.
 - (x) Savings from the reduction in paperwork.
 - (xi) Savings from having a partially Web accessible medical record which will eliminate redundant scanning and testing.
- (3) Additional Annual Appropriations to USNHP- Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the program. These funds may occasionally be taken from the national treasury with approval of the Senate.
- (4) Adjustable Parameters- Due to probable funding and expense variability in this Program, the Director General may, from time to time, make adjustments to certain built in parameters to favorably affect the expense to income ratio. These parameters include;
- (i) Adjustment in the individual and employer premium amounts.
 - (ii) Adjustment in the “financial means adjustment” for individuals, families, and employers.
 - (iii) Adjustment in the co-payment amount.
 - (iv) Adjustment in the medication reimbursement amounts.
 - (v) Reduction in services, beginning with the least medically significant items, as to be defined as the Program develops.
 - (vi) Reduction in coverage or payment amounts for select assistive equipment.
 - (vii) Reductions in provider payments, as a near-last resort, but in keeping with the then current economy and financial trends.

Sec.312. Appropriations from Existing Programs for Uninsured and Indigent

Notwithstanding any other provision of the law, there are hereby transferred and appropriated to carry out this act, amounts equivalent to the amounts as the Secretary estimates would have been appropriated and expended for Federal public health care programs for the uninsured and indigent, including funds appropriated under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such act, and under the Children's Health Insurance Program under title XXI of such act.

Title IV—Administration: Private verses Public Administration

Sec.400. Private Administration- There is a variety of ways that a public option could be offered by the existing private insurers. A number of the existing insurers could each offer a non-profit public insurance option. All plans administering the public option would have to offer a Program established set of benefits for their enrollees as well as a Program established payment schedule for providers of care and services. More than one public option plan could be set up in each for many geographic regions so that they may compete with each other for enrollees and for provider participation. Competition for healthcare improvement would be entrenched for the first time ever in the United States. A summary of the above and further specifics are as follows:

1. Establishment of the standards of enrollee benefits and of a payment schedule for providers of care and require that all of the participations administrators of this public option adhere to the criteria. These criteria could only be modified by the Program itself.
2. Funding of these plans would be through a combination of an income adjusted premium assessed to all and by Federal supplementation of that funding based on the numbers of patients in any plan that cannot meet their premium payments.
3. Require the offering of more that one plan in a given geographic area. If more than on private administrator can not be found for that area, a publically administered plan may be required, to supply competition.
4. Competition between these plans for enrollees and for providers will occur. For the first time, insurers would find it in their best interest to be enrollee and provider friendly.
5. A common information system would be required so as to facilitate the accumulation of a basic set of metrics to allow aggregate analysis of the healthcare status and utilization of the enrollee population of each plan.
6. A common information system would also allow provider specific tracking of quality and resource consumption that would be adjusted for the basic metrics of their specific patient population. Improvement over time would be tracked.

7. A Public Option Program office shall be established to ensure that all participating private administrators of this public option shall perform as required.
8. For any given plan administrator, the improvement in the health and resource utilization of the enrollees coupled with any improvement in the efficiency of the providers would allow for the accumulation of excess funds above expenses. These excess funds could be utilized to reward compliant patients, provider efficiency, and for corporate profit. Details are to be considered.
9. As more of the private insurers request to administer the Public Option Plan, the specifics of the following section on Public Administration become less important and may evolve to be simply a department of oversight and compliance.

Sec.401. Public Administration- To be utilized if the private insurers will not or cannot privately administer the Public Plan Option in suitable numbers as outlined above.

1. Except as otherwise specifically provided, this Act shall be administered under the Secretary of Health and Human Services by a Director General (DG) appointed by the Secretary and approved by the Senate. The DG is charged with the overall management of the USNHP.
2. There shall be established a National Board of HealthCare (NBHC), Sec.409.
3. The Director General shall appoint, with the approval of the Secretary, a Director of Quality and Access (DQA), Sec402.
4. The Director General shall appoint, with the approval of the Secretary, a Director of Equipment and Facilities (DEF), Sec.403.
5. The Director General shall appoint, with the approval of the Secretary, a Director of Long Term Care (DLTC), Sec.404.
6. The Director General shall appoint, with the approval of the Secretary, a Director of Mental HealthCare (DMHC), Sec.405.

Sec.402. Office of Quality and Access

The Director General shall appoint a Director for an Office of Quality and Access. Such director shall appoint, with the approval of the Director General, a series of Regional Directors (RD), who shall in turn appoint, with the approval of their respective RD, a series of State Directors (SD), one for each state in their region. The DQA, after consultation with the state and regional directors, shall provide annual recommendations to Congress, the President, the Secretary, the Director General and other USNHP officials (the latter to be determined) on how to help ensure the highest quality healthcare access and delivery of service. The DQA shall conduct an annual review of the adequacy of medically necessary services, of the healthcare provider panel, and of the number and

distribution of hospital beds and of out-patient facilities, and then shall make recommendations of any proposed changes to the Congress, the President, the Secretary, the Director General and other USNHP officials (the latter to be determined).

Sec.403. Office of Equipment and Facilities

The transition from private to public ownership of the health care delivery system will require a complete assessment of the facilities and equipment available to each patient and their providers of care. The Director of Equipment and Facilities (DEF) shall be charged with working through the SD and the DQA to conduct such review and cause these facilities and equipment to be provided as is fiscally possible at that time and to be as conveniently placed as is feasible to ensure availability of care to all persons

Sec.404 Office of Long Term Care

The Director General shall appoint a Director for Long-Term Care (DLTC) who shall be responsible for the administration of this Act and for ensuring the availability, accessibility, and cost effectiveness of high quality long-term care services. Data shall be collected through the SD for these purposes. The DLTC shall work through the DEF and the DQA to ensure that access and quality of care for long-term patients is of high quality and comparable to that supplied by the system as a whole.

Sec.405. Office of Mental HealthCare

The Director General shall appoint a Director for Mental HealthCare who shall be responsible for the administration of this Act and for the ensuring the availability, accessibility, and cost effectiveness of high quality mental health services. Data shall be collected for these purposes through the SD. The DMHC shall work through the DEF and the DQA to ensure that access and quality of care for mental health patients is of high quality and comparable to that supplied by the system as a whole.

Sec.406. Regional and State Administration

- (a) Use of Regional Offices- The Director General shall cause to be established and maintained a series of regional offices. Each region shall have a Regional Board (RB) composed of the State Directors of that region and chaired the Regional Director. Such regional offices shall incorporate and replace the current Medicare regional offices.
- (b) Appointment of Regional and State Directors- In each such regional office there shall be—
 - (1) One Regional Director (RD) appointed by the DQA and approved by the Director General; and
 - (2) For each State in the region, a State Director (SD) appointed by the RD and approved by the DQA.
- (c) Regional Office Duties-

- (1) In General- regional offices of the Program shall be responsible for—
 - (A) Coordinating funding to health care providers and physicians; and
 - (B) Coordinating billing and reimbursements with physicians and health care providers through a state-based reimbursement system.
- (d) State Directors Duties- Each State Director shall be responsible for the following duties:
 - (1) Establishing and staffing a series of local/district offices, the number of which will be decided by the Director General based on the intensity of services needed in a given area.
 - (2) Providing an annual state healthcare needs assessment report to the National Board of HealthCare and the regional board, after a thorough examination of health needs, in consultation with public health officials, clinicians, patients and patient advocates.
 - (3) Health planning, including oversight of the placement of new hospitals, clinics, acquisition of existing structures and equipment, and other health care delivery facilities.
 - (4) Health planning, including oversight of the purchase and placement of new health equipment to ensure timely access to care and to avoid duplication.
 - (5) Submitting global budgets to the regional director.
 - (6) Recommending changes in provider reimbursement for payment for delivery of health services in the state. These changes must be globally compatible with provider reimbursements across the entire system.
 - (7) Establishing a quality assurance mechanism in the state in order to minimize both under utilization and over utilization and to assure that all providers meet high quality standards.
 - (8) Reviewing Program disbursements on a quarterly basis and recommending needed adjustments in the services provided, individual and employer payments schedule, and provider disbursements as needed to achieve budgetary targets and assure adequate access to needed care. This may include requesting a larger contribution from the Program.

Sec.407. Employment of Displaced Healthcare Industry Clerical workers

First Priority in Retraining and Job Placement- The Program shall provide the clerical, administrative, and billing personnel in insurance companies, doctors offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration needs resulting from the implementation of this program-

- (1) Should have first priority in retaining and job placement in the new system assuming they are in good standing in their current employment; and
- (2) Shall be eligible to receive unemployment benefits, which may be extended up to two years at the discretion of the Director General after analyzing the current state of job opportunities for those employees.

Sec.408. Confidential Electronic Patient Record System

- (a) In General- The Secretary shall cause to be created a standardized, confidential electronic patient record system in accordance with laws and regulations to maintain accurate patient records and to simplify the billing process, thereby reducing medical errors and tracking of fraud and abuse.
- (b) Patient Options- Notwithstanding that all billing shall be performed electronically as soon as possible or as detailed in (c) below, access to the majority of the EMR shall be kept private and under the control of the patient in conjunction with their primary care provider.
- (c) This medical record shall be “Web accessible” with full access controlled by the primary care provider and the patient. All consults, studies, lab work, surgeries, emergency room visits, et cetera, shall be posted to the site in real time with notification to the primary care provider to review newly added content. Private vendors shall be required handle program input/output through a common interface that can communicate with other programs via the Internet.
- (d) A section of the EMR, termed “Quality Metrics” shall include data on basic health information such as sex, age, height, weight, blood pressure, pulse, cholesterol laboratory measures, diabetic laboratory measures, current medications, medication allergies, and other key public health metrics to be decided on further review. General access to an individuals private health records will not be allowed.

Sec.409. National Board of HealthCare

- (a) Establishment-
 - (1) In General- There is established a National Board of Health Care (NBHC), in this section referred to as the Board, consisting of 14 members appointed by the President (by and with the advice and consent of the Senate) and chaired by the Director General. The NBHC is charged with advising the DG and working with the DG to appropriately manage the USNHP and to plan for its future. This Board shall be composed of private citizens and will be independent of political influence, much like the Federal Reserve Board.
 - (2) Qualifications- The appointed members of the Board shall include the following and they shall have equal votes:
 - (A) Healthcare professionals- 6 members.

- (B) Representatives of institutional providers of health care- 4 members.
- (C) Representatives of health care advocacy groups- 2 members.
- (D) Citizen patient advocates- 2 members.
- (9) Terms- Each member shall be appointed for a term of six years, except that the president shall stagger the terms of members initially appointed so that the terms of no more than three members expire in any year.
- (10) Prohibition on Conflicts of Interest- No member of the board shall have a financial or social conflict of interest with any of the duties before the board.
- (11) The Secretary shall be encouraged to attend the meetings of the Board as a non-voting member.

(b) Duties-

- (1) In General- The Board shall meet at least twice per year, including a comprehensive annual meeting, and shall advise, individually or in aggregate, the Director General on a regular basis throughout the year to ensure quality, access, and affordability.
- (2) Specific Issues- the Board shall specifically address the following issues, among others;
 - (A) Access to care
 - (B) Quality and quality improvement
 - (C) Efficiency of administration
 - (D) Adequacy of budget and funding
 - (E) Appropriateness of reimbursement levels of physicians and other providers
 - (F) Capital expenditure needs
 - (G) Long-term care services
 - (H) Mental health and substance abuse services
 - (I) Staffing levels and working conditions in the health care delivery facilities
 - (J) Cost effectiveness of all endeavors of the USNHP
 - (K) Sustainability of the Program over time
- (3) Establishment of Universal, Best Quality Standard of Care- The Board shall specifically establish a universal, best quality standard of care with respect to—
 - (A) appropriate staffing levels,
 - (B) appropriate medical technology,
 - (C) design and scope of work in health workplace, and
 - (D) best medical practices
 - (E) preventative medicine
 - (F) advocating for a healthy life style for its enrollees.
- (4) Twice-a-Year report- The Board shall report its recommendations twice each year to the Secretary, Congress, and the President.

- (c) Compensation, etc- The following provisions of section 1805 of the social security act shall apply to the Board in the same manner as they apply to the Medicare Payment Assessment Commission (except that any reference to the commissioner or the comptroller general shall be treated as references to the Board and the Secretary, respectively):
- (1) Subsections (c) (4) (relating to compensation of board members).
 - (2) Subsections (c) (5) (relating to chairman and vice chairman).
 - (3) Subsection (c) (6) (relating to meeting).
 - (4) Subsection (d) (relating to the director and staff; experts and consultants).
 - (5) Subsection (e) (relating to powers).

Title V—Additional Provisions

Sec.501. Treatment of VA, HIS, and Local Health Department Programs

- (a) VA Health Programs- This act provides for health programs of the department of veterans affairs to initially remain independent for a five-year period that begins on the date of the institution of the USNHP. After such five-year period, Congress shall reevaluate whether such program shall remain independent or be integrated into the USNHP.
- (b) Indian Health Service programs- This act provides for health programs of the Indian Health Service to initially remain independent for the five-year period that begins on the date of the institution of the USNHP, after which such programs shall be integrated into this program.
- (c) Local Public Health Departments may continue to function for a maximum of five years. They are expected to be absorbed into the Program before or by that time.

Sec.502. Public Health and Prevention

It is the intent of this act that the program at all times addresses the importance of good public health, prevention of disease, and good health habits by all.

1. Utilization of one information system will allow provider specific quality data will be established and monitored over time.
2. Individual patient progress will be evaluated and perhaps their premium decreased for progressive improvement.
3. Self-destructive habits will be discouraged by a small premium increase.

4. Patient specific communications through their primary care providers will give ongoing healthcare feedback and suggestions for improvement.
5. Preventive healthcare information will be standardized and provided to patients at the time of their office visits as well as through the internet, etc.

Sec.503. Reduction in Health Disparities

It is the intent of this act to reduce health disparities by race, ethnicity, income, and geographic region, and to provide high quality, cost effective, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, religion, or language.

Sec.504. Reform on the Medical Malpractice Laws

In reducing the cost of running a national health program, reforming the malpractice legal system is critical.

- (a) Legislation will be passed to remove medical malpractice issues from the civil courts.
- (b) There will be established a series of free standing three to five member arbitration panels whose job it is to review poor medical outcomes and to definitively rule on the following items, among others:
 - (1) Does the patient/plaintiff require compensation for ongoing care and support, and to then fairly assign an amount based on similar cases across the whole USNHP system?
 - (2) Was the provider in error or was the event the result of an accepted medication side effect, operative procedure, or simply a bad outcome?
 - (3) Does the Provider need re-education?
 - (4) Does the provider need punishment or revoking of license?
 - (5) Are there education issues that would benefit the system as a whole?
- (c) The above arbitration panels would consist of medical professionals, legal representatives, and patient advocates. The State's medical society, the State's legal society, and the State's Governor may appoint them, respectively. They would be given six-year terms, staggered so that no more than one third of the terms are up in any given year. Compensations will be derived from the USNHP operational funds designated for disability maintenance.

Sec.505. Continuing Medical Education

The Director will cause to be established a system of continuing medical education for all healthcare professionals. This system should supply a continually updated and computer based continuing medical education at no or nominal charge. This system will also serve as a mechanism for disseminating information relating to process improvement, medical error alerts and education, medication recalls, and other system wide urgent medical information that would benefit healthcare delivery. All providers shall be required to continually and satisfactorily complete their respective programs.

Sec.506. Continuing Clerical Education

The Director shall cause to be established a computer based continuing educational system for clerical and support staff to insure a base of knowledge, efficiency of practice, courteous behavior and the confidentiality of health information. All clerical staff shall be required to continually and satisfactorily complete their respective programs.

Title VI—Effective Date

Sec.601. Effective Date

Except as otherwise specifically provided, this act shall take effect six months after passage of this act, and shall apply to items and services furnished to enrolled patients on or after such date.

END