Market-Based Healthcare Reform for the 21st Century Act

IN THE CONGRESS OF THE UNITED STATES

May 9, 2022

For Mrs. Athena Sinclair-Kasparian ,herself and Mr. Threes Twos

Introduced the following piece of legislation.

A BILL

To provide reasonable reforms to the Affordable Care Act so that healthcare is truly affordable. Along with providing measures to bring down drug costs, end surprise billing, expand telehealth, reform malpractice laws, provide reforms to Medicare and Medicaid to decrease costs while improving care.

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

SECTION I. Short Title

I. This act may be cited in public works as the "Market-Based Healthcare Reform for the 21st Century" Act or "MBHRTFC"

SECTION II. Guaranteed Protections

I. Medicare, Medicaid, Employer, and Private insurers are prohibited from denying coverage or discriminating in relation to prices and medical treatment against anyone with pre-existing conditions.

II. Insurers are prohibited from imposing annual or lifetime caps on coverage.

III. Insurers are forbidden from dropping policyholders when they become ill.

IV. Insurers must spend at least 80–85% of premium dollars on health costs; rebates must be issued if this is violated.

V. Dependents are permitted to remain on their parents' health insurance plan until their 26th birthday including:

   A. dependents who no longer lived with their parents,

   B. are not dependent on a parent's tax return,

   C. are no longer a student

   D. or are married.

VI. All health insurance plans must cover 10 essential benefits:

   A. Chronic disease management, preventive care, and wellness services;

   B. Outpatient care (or “ambulatory patient services”);

   C. Emergency services;

   D. Hospitalization (inpatient care);

   E. Laboratory services;

   F. Prescription drugs

   G. Mental health and substance use disorder services, including behavioral health treatment;

   H. Rehabilitative or habilitative services and devices;

   I. Maternity and newborn care; and

   J. Pediatric services

VII. This section shall only go into effect in the effect the Affordable Care Act is repealed or struck down in the courts

SECTION III. Expanding Coverage

I. Short-term Limited Duration insurance plans (STLD) are to be allowed to provide to policyholders.

A. Short-term Limited Duration insurance is defined as

1. health insurance coverage plan provided pursuant to a contract with a health insurance issuer that has an expiration date specified in the contract (not taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 12 months after the original effective date of the contract.

B. Short-term duration plans shall be exempt from covering all 10 essential health benefits but are prohibited from dropping holders when they get sick.

C. Persons shall be eligible for STLDs while in between long term insurance plans

II. This section shall restore the 5:1 ratio in which insurers can charge their most to least costly plans.

III. Citizens and Permanent Residents shall be eligible to purchase various healthcare plans across state lines.

A. Hospitals, primary care provider, outpatient, and in-patient centers shall be prohibited from denying care to a person if they are enrolled in an out of state plan,

B. If a policyholder is enrolled in an out-of-state plan then they shall be applicable to all laws and regulations regarding healthcare in the origin state along with laws and regulations in the state that policyholder resides.

SECTION IV. Improvements to the private market.

I. The individual mandate shall be repealed.

A. An insurer shall be allowed to impose a 25% surcharge for the first 6 months of a policyholder being enrolled if a person goes more than 180 days without enrolling in a plan.

1. If a person enrolls in an STLD plan they will not have to pay a surcharge.

II. Employers with 50 or more employees shall no longer be required to offer health insurance as an employee benefit.

III. A new "Copper Tier" shall be added to the Marketplace exchanges.

A. Copper-level plans will have an actuarial value of 50% and will have out-of-pocket limits that are 30% higher than bronze plans.

IV. Adjusts premium assistance to incorporate both means-tested and age-adjusted tax credits as to individuals in certain age groups and income groups pay no more than a certain percentage of their income as listed below:

Federal Poverty Level (FPL)	Up to Age 29	Ages 30-39	Ages 40-49	Ages 50-59	Over 59
Up to 100%	0	0	0	0	0
100%-133%	2	2	2	2	2
133%-150%	3	3.2	3.4	3.4	3.6
150%-200%	4	4.2	4.4	4.4	4.6
200%-250%	5	5.2	5.4	5.6	5.8
250%-300%	6	6.2	6.4	6.6	6.8
300%-400%	7	7.2	7.4	7.6	7.8
400%-600%	8	8.5	9	9.3	9.5

A. Premium assistance eligibility shall be based on the previous year's tax return.

V. Insurers shall be allowed to enroll individuals in exchange plans outside of open enrollment periods if they wish.

A. If they do this then they shall have the ability to impose a late fee as long as it is not an open enrollment period.

VI. A new waiver shall be established to allow for states to hold open enrollment periods every 24 or 36 months instead of one every 12.

A. A state's executive authority shall apply for a waiver through the Department of Health and Human Services.

VII. Repeals the ACA ban on the construction of new physician-owned hospitals;

VIII. Private insurers in a given state shall be able to jointly negotiate reimbursement rates and network access with regional hospital systems.

IX. Requires hospitals in extremely concentrated markets to accept Medicare Advantage rates from all payers with hospitals and payers free to negotiate rates that are lower than MA rates in these settings.

A. Rural areas are exempt from this provision.

X. Gag clauses on price and quality information and anti-competitive terms in payer-provider contracts are prohibited,

XI. Repeals the McCarran-Ferguson antitrust exemption for health insurance plans.

SECTION V. Price Transparency

I. Hospitals are required to publish, in a standardized digital format, average prices for their 100 most common shoppable services.

II. Grants HHS the statutory authority to require that providers and payers disclose their negotiated prices.

III. Establishes a national all-payer claims database to create transparency into prices negotiated by insurers and providers, including those covered under ERISA plans exempt from state regulation.

IV. Insurers are required to have up-to-date directories of their in-network providers.

V. Policyholders are to access all cost-sharing information.

VI. Patients shall have ownership of all diagnostic tests and objective clinical measurements conducted on their behalf.

VII. Health care facilities are required to give patients bills for performed services within 45 days.

A. The patient will have at least 30 days to pay bills upon receipt.

VIII. An advisory group shall be formed to consult with the HHS Secretary on administrative burdens faced by hospitals that increase costs.

A. This group shall be comprised of 24 individuals all of which are to have a medical background.

1. These individuals shall range from all areas of healthcare areas including and not limited to:

a) Hospital administers

b) Doctors

c) Insurance agency trustees

d) State and Federal health regulators.

B. This advisory group shall deliver an annual report to Congress based on their findings and give recommendations.

C. This group shall dissolve after 5 years unless extended by act of congress,

IX. Requires participating 340B entities to report to HHS the number of individuals dispensed drugs under this program, whether they belong to Medicare, Medicaid, or other insurance, the total costs incurred and reimbursements received.

A. This data will be made public on the HHS website and the OIG, GAO, and Comptroller General will provide subsequent reports based on the data.

X. Employers who provide health insurance for 100 or more employees shall be required to provide certain information to those beneficiaries.

A. On an annual basis, each beneficiary will be informed of the amount the employer paid for their coverage for that plan year, as well as any previous plan years in which the employer paid for their coverage.

XI. Requires that insurers submit to the HHS Secretary an annual report on health claims spending.

XII. The Government Accountability Office shall deliver a report on profit-sharing relationships between the hospitals, contract management groups, and physician and ancillary services.

SECTION VI. Medicare

I. Medicare Part B beneficiaries shall have the ability to select their own primary care physician.

A. Beneficiaries are not liable for more than $5 per visit to their selected physician.

1. The physician may receive a monthly fee under Part B for providing services such as preventive care, vaccinations, and communications to the beneficiary.

B. The Secretary is responsible for providing a list of standardized benefits that are included in the payment.

II. Individuals 65 and older, with a lifetime reported earnings exceeding $10 million, are prohibited from enrolling in Medicare Part B and Part D coverage, or other Medicare supplemental policies.

A. These individuals may still receive Medicare Part A coverage.

III. Individuals shall have the option to opt-out of Part A coverage without losing social security benefits.

A. An individual who opts out of Part A will also terminate benefits under Part B,

B. An individual that opts out of Part B terminates benefits under Part A.

C. Establishes a special open enrollment period, without a late enrollment penalty, for individuals who receive either Parts A or B coverage and wish to be enrolled in both.

IV. No late enrollment penalty will be assessed if new beneficiaries for Medicare had any health coverage prior to enrollment.

V. All Medigap plans must offer guaranteed coverage as described under the Affordable Care Act and Section I of this bill.

VI. There shall be a max $10,000 out-of-pocket spending cap for beneficiaries under Medicare Part A and B.

VII. An online platform shall be established for beneficiaries to enroll in easily comparable Medicare Advantage, Fee-For-Service (FFS), and Accountable Care Organization (ACO) plans.

A. Medicare Advantage plans will be required to have an actuarial value equivalent to FFS coverage under Parts A and B and can only introduce two supplemental benefit plans.
    1. FFS and ACO enrollees will still have access to Medigap plans.
B. Competitive bidding markets will be tied to metropolitan statistical regions with benchmark premiums based on the weighted average (by enrollment in the previous year) of the premium bids from Medicare Advantage plans, ACOs, and the per-person costs of FFS cost – minus the statutory Part B premium.
C. Beneficiaries enrolling in a Medicare Advantage plan will pay the difference above the benchmark rate for higher-cost plans or receive 100% of the savings for plans with premiums below the benchmark.
D. Medicare Advantage plans can offer multi-year contracts with guaranteed premiums.
    1. For beneficiaries enrolling in FFS Medicare after the enactment of this Act, premiums can only increase $20/month year-over-year for 5 years to limit cost increases.

VIII. Enacts site-neutral payment from Medicare for health care services performed in a hospital-owned facility and a non-hospital-owned facility.
    A. Site-neutral payment is defined "as paying the same rates for the same care, regardless of whether or not it takes place in a hospital or an outpatient clinic"

SECTION VII. Drug Prices

I. The Secretary of Health and Human Services shall have the ability to negotiate prices on certain prescription drug prices.
    A. The secretary can negotiate prices for up to 125 prescription drugs a year.
        1. 50 of these drugs must be from the highest costing single-source, brand-name drugs for medicare.

2. 50 of these drugs must be newly approved single-source, brand-name drugs.
3. 25 of these drugs shall be personally picked by the secretary.

B. All negotiated costs are to not exceed 120% of the average price in Australia, Canada, France, Germany, Japan, and the United Kingdom.
1. If no price information is available in these countries then the negotiated price is 85% of the U.S. average manufacturer price.

C. All negotiated prices are required to be available to private insurers.
1. A private insurer may opt-out.

D. Drug manufacturers that fail to comply with this section's negotiation requirements, shall be subject to a 30% value-added tax penalty for 5 years.
1. This tax will apply to all levels of production for the manufacturing of a drug that fails to comply with the requirements.

II. Drug manufacturers are required to pay a rebate to the Centers for Medicare & Medicaid Services (CMS) for covered drugs under Medicare that cost $100 or more and for which the average manufacturer price increases faster than inflation.

A. Each rebate paid to the CMS will equal the difference of total cost exceeding the rate of inflation.
1. HHS will use the CPI-E formula to measure inflation for prescription drugs covered under Medicare.

III. States shall have the ability under this section to apply for a waiver from the Secretary to import from Australia, Canada, France, Germany, Japan, United Kingdom, and South Korea.

A. Each waiver must state the drug that it wishes to import and what country it will be coming from.

B. If a waiver is approved then the described drug must first be FDA approved and transported through a legal port of entry.

IV. There shall be a max market price cap of $125 for the cost of insulin.

A. The max market price cap shall be adjusting for inflation each year using the Chained CPI formula.

V. Eliminates the role of pharmacy benefit manager (PBM) rebates in steering patients to cost-ineffective drugs.

A. PBMs are required to steer patients to the most effective drugs regardless of cost.

VI. Requires PBMs to disclose to insurers the costs, fees, and rebate information associated with their contracts.

VII. Eliminates the ability of PBMs to retroactively charge pharmacies for price increases.

SECTION VIII. Medicaid

I. States shall have the option to receive a "per-capita allotment" for coverage of their legacy Medicaid population in lieu of expanding Medicaid under the Affordable Care Act.

A. States that choose this option will have the flexibility to determine who qualifies for Medicaid in their state and will receive federal funds reflecting the number of enrollees in the program.

B. Legacy Medicaid population is defined as "a state's Medicaid population 2 years prior to the enactment of this bill"

C. States shall receive $10,000 per enrollee.

1. This figure shall be adjusted for inflation using the CPI-E formula.

D. In states that have elected the per-capita allotment option for Medicaid, individuals whose incomes are below 600% FPL and above the threshold for eligibility in the state's Medicaid program as of January 1, 2019, shall be eligible for premium subsidies from the federal government.

II. States shall be allowed to hire outside contractors to conduct Medicaid eligibility redeterminations and allow states to assess an individual's Medicaid eligibility every 6 months or more frequently.

III. States, through an 1115 waiver, shall be granted the ability to design programs to allow direct primary care arrangements (DPC) for low-income individuals enrolled in their state Medicaid program.

IV. States shall be able to receive a waiver to set up work requirements for able-bodied persons enrolled in state Medicaid programs.

A. In order to receive a waiver, a state must apply through the Department of Health and Human Services and have the application approved by the Secretary of HHS.

1. An application for a waiver must be signed by the state's Department of Health and a state's executive authority with the approval of its legislative body.

B. Each program must include the following

1. Exemptions:

a) on disability

b) is a single parent

c) unable to find work

(1) Must provide valid proof recipients are actively looking for work.

(a) Valid proof is defined as "a job application"

d) above the age of 55

e) under the age of 26.

2. A max minimum hourly requirement of 18 hours a week.

C. Requirements, if approved, can be suspended or delayed by the secretary or president during times of economic recession.

SECTION IX. Tax Provisions

I. Employers shall be able to deduct business-expenses contributed toward prescription drug coverage under Medicare Part D for retirees from their taxes without reductions due to federal subsidies.

II. The 2.3% Tax on Medical Device Manufacturers created under the Affordable Care Act is hereby repealed

III. The 40% Excise Tax "Cadillac" on high-end Premium Health Insurance Plans Created under the Affordable Care Act is hereby repealed.

IV. Decrease the tax on insurance agencies from 35% to 23.5%.

SECTION X. Invisible Guaranteed Coverage Pool Reinsurance Program

I. Implements a reinsurance program using an invisible high-risk pool approach.

II. Authorizes $200,000,000,000 over ten years to HHS for the establishment of such a program.

A. $20,000,000,000 shall be allocated annually.

III. States shall participate in a nationwide, federally-operated pool, or choose to receive a block grant composed of an appropriately portioned amount determined by the Secretary to run separate pools.

IV. A $4 fee attached to exchange policies will contribute to funding the pool and an HHS report, in collaboration with the GAO, will be published after 5 and 10 years to provide oversight on the funding of this pool.

V. Insurance companies in states that participate in the federal program shall designate policies for placement in the pool and may do so at any time.

A. They may place individual policies as well as family policies into the pool, but they cannot separate one individual from a family policy for placement in the pool.

VI. When an insurance company places a policy in the pool, that policy takes on a "high-risk" designation, but policyholders are not notified of the designation.

A. From insurers' perspective, two features of high-risk plans separate them from the rest.

1. First, insurers retain only 10% of the monthly premiums paid for these high-risk policies.

2. The remaining 90% shall be submitted to the fund sustaining the pool.

B. Insurers are responsible only for the first $10,000 in annual medical costs incurred by individuals on high-risk policies.
    1. Subsequent costs are payable at the Medicare Advantage rate and are reimbursed by the fund sustaining the pool.
    2. For services not covered by Medicare, the Secretary may establish an appropriate dollar amount.

SECTION XI. Malpractice Reform

I. Malpractice lawsuits are to occur no longer than 3 years after the relevant medical treatment or no longer than 1 year after a patient discovers that he or she is injured.

II. Non-economic damages from malpractice litigation are limited to $250,000.

III. Attorney contingency fees are capped to 40% of the first $50,000 recovered, 33% of the next $50,000, 25% of the next $500,000, and 15% of any amount above $600,000 so that the majority of damages are awarded to patients, not lawyers.

IV. Requires periodic payments of damages to a minimum of 1 payment per fiscal quarter.

V. Health care providers shall be immune from product liability for the lawful use of FDA-approved prescription drugs and medical devices.

VI. Physician expert witnesses are limited to those licensed to practice in the defendant's state or a contiguous bordering state, and practice in a specialty that is relevant to the case.

VII. Physician apologies or other expressions of sympathy are inadmissible for any purpose as evidence of an admission of liability in a malpractice lawsuit.

SECTION XII. Medisave

I. New Medisave Accounts (MDAs) shall be established for eligible individuals to save and spend pre-tax earnings towards qualified medical expenses.

II. MDAs shall have a yearly contribution limit of $5,000 on a sliding scale with an accruing total of $50,000.

A. Individuals with insurance plans that are above 80% actuarial value are not eligible for MDAs unless those plans meet high deductible health plan (HDHP) thresholds, or if the individual has an income below 250% FPL.

III. Unused advance premium tax credits can be directly deposited into MDAs and employers may make contributions tax-free if the individual is not already receiving APTCs.

IV. MDA funds that are used to purchase non-qualified medical expenses will have a 20% tax and no payment for a qualified medical expense shall count toward the Medical Expense Deduction.

V. Within one year of enactment, holders of legacy health care savings accounts like Health Savings Accounts, Health Reimbursement Arrangements, Flexible Spending Accounts, and Medical Savings Accounts will be required to deposit these monies into MDAs in order to preserve their tax-free status.

A. There will be no contribution limit for this one-time transition.

B. Employers will be required to allow workers to convert their employer-owned HRA balances into the new employee-owned MDAs.

VI. New businesses incorporated on or after December 31, 2021, that wish to sponsor tax-advantaged health insurance for their workers, must do so by offering MDAs to their workers.

VII. Appropriates $5,000,000 to the Department of Health and Human Services for a public awareness campaign to promote MDAs.

SECTION XII. Ending Surprise Billing

I. Out-of-network service providers are required to give patients 72-hour notice of their estimated charges for treatment.

A. Patients would have to agree to receive out-of-network care from the hospital or doctor to then bill them.

II. Air ambulance services are prohibited from sending patients to surprise bills for more than the in-network cost-sharing amount.

III. Patients are only responsible for their in-network cost-sharing amounts, including deductibles, in both emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider.

IV. The practice of balance billing is hereby prohibited for healthcare providers and facilities.

    A. Balanced billing is defined as "a medical bill from a healthcare provider billing a patient for the difference between the total cost of services being charged and the amount the insurance pays to providers who are out of network, and therefore not subject to the rates or terms of providers who are in-network.

V. Requires healthcare facilities and practitioners to give patients a list of services received upon discharge or end of a visit or by postal or electronic communication as soon as practicable and not later than 15 calendar days after discharge or date of visit.

    A. Healthcare facilities and practitioners are required to submit medical bills to patients with 90 days of discharge.

        1. If a patient receives a bill after the 90 day period they will not be obligated to pay the bill.

    B. Healthcare facilities and practitioners are required to give patients at least 45 days after the postmark date to pay bills.

    C. The timeline for submitting a bill may be extended if a patient or their provider is appealing an adverse coverage determination, or if an out-of-network provider is disputing a payment through open negotiation or Independent Dispute Resolution.

VI. Provides for a 30-day open negotiation period for providers and issuers to settle out-of-network claims.

A. In the event that the parties are unable to reach a negotiated agreement, they may access a binding arbitration process – referred to as Independent Dispute Resolution (IDR) – in which one offer prevails.

1. Providers may batch similar services in one proceeding when claims are from the same issuer.
2. The IDR process will be administered by independent, unbiased entities with no affiliation to providers or issuers.
    a) The IDR entity is required to consider the median in-network rate, alongside relevant information brought by either party, information requested by the reviewer,
        (1) as well as factors such as
            (a) the provider's training and experience,
            (b) patient acuity and the complexity of furnishing the item or service,
                (i) in the case of a provider that is a facility,
                    (a) the teaching status,
                    (b) case-mix and scope of services of such facility,
                    (c) demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement,
                    (d) prior contracted rates during the previous four plan years, and other items.
3. Following IDR, the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a determination by the IDR entity, in order to encourage settlement

of similar claims, but all claims that occur during that 90-day period may still be eligible for IDR upon completion of the 90-day period.

SECTION XIII. Telehealth

I. Medicare shall expand allowable and billable telehealth coverage to include applicable services furnished by a certified diabetes educator or licensed respiratory therapist, audiologist, occupational therapist, physical therapist, or speech-language pathologist.

II. The Secretary shall have the authority to waive off telehealth restrictions regarding geographic limitations, types of technology, types of providers, types of services when certain criteria are met and hold a 60 day public comment period for the waivers.

A. Certain criteria are to include but not limited to:

1. Mass disease outbreaks such as an epidemic and/ or pandemic.
2. Bio-terrorism
3. Economic recession
4. Public health emergency

a) There shall be no public comment period during a public health emergency in relation to this section.

III. There shall be no geographic restrictions for mental health services, emergency medical care services, federally qualified health centers, rural health clinics, facilities of the Indian Health Service, Native Hawaiian Health Care Systems.

IV. A patient's place of residence shall serve as an originating site in all telehealth services.

SECTION XIV. Definitions

I. Doctor is defined as "a qualified practitioner of medicine".

II. Policyholder is defined as "a person enrolled on a public or private healthcare plan".

III. Inpatient care is defined as "the care of patients whose condition requires admission to a hospital"

IV. Outpatient care is defined as “medical procedures or tests that can be done in a medical center without an overnight stay”

V. HHS is defined as “the Department of Health and Human Services”.

VI. The Secretary is defined as the “the Secretary of Health and Human Services”

VII. All references in Section II will follow the ACA definitions.

VIII. Prescription drugs are defined as “a pharmaceutical drug that legally requires a medical prescription to be dispensed.”

IX. Telehealth is defined as “the distribution of health-related services and information via electronic information and telecommunication technologies”.

X. Insurer is defined as “a health insurance plan provider”.

SECTION XV. Enactment

I. The provisions of this Act shall go into effect in one year, upon its signature by the President.

SECTION XVI. CBO Estimation

I. Costs over 10 years:
    A. Medicare Cap on out-of-pocket: $113 billion
    B. Employer mandate repeal: $21 billion
    C. Other tax cut provisions: $75 billion
    D. Reinsurance pool: $200 billion
    E. Per-capita Medicaid option: $163 billion
    F. Premium adjustment: $46 billion
    G. Total: $618 billions
        1. 61.8 Billion a year

II. Savings over 10 years:
    A. Drug pricing negotiation: $456 billion
    B. Malpractice reform: $69 billion
    C. Other drug pricing reform: $72 billion
    D. Competitive bidding for medicare: $72 billion
    E. All other provisions: $11 billion

F. Medicaid work requirement waiver: $50 billion

G. Increased hospital competition: $100 billion

H. Site neutral payment: $142 billion

I. Total: $972 billion

1. 97.2 billion a year

III. This legislation will REDUCE the federal deficit by $354 billion over 10 years.

A. 35.4 Billion a year

IV. An estimated 100 million people would have expanded healthcare options and an estimated 9 million would gain insurance.

V. Drug prices could see a price reduction ranging from 57% to 75%.