INTRODUCTION AND OVERVIEW

This document is a hypothetical legislative Senate bill. The purpose for creating this bill is to suggest possible principles and ideas for correcting or controlling some of the less discussed and less visible issues within the health care industry that pose disservices to both consumers and National strategic needs. This document is meant to stimulate discussion and encourage national policy dialogue.

1 **Calendar No. #**
2
3 # CONGRESS
4 # SESSION

5 **S. #**

6
7 **To establish controls for managing monopolies and adverse conduct, quality, and national**
8 **economic impacts in that segment of the strategic national infrastructure known as commercial**
9 **healthcare.**
10
11
12
13
14
15 **IN THE HOUSE OF REPRESENTATIVES**
16
17 [date]
18 [elected representative] (for Mr. R. Lewis of North Carolina) introduced the following bill.
19
20
21

1
A BILL
2
3
4 TO ESTABLISH CONTROLS FOR MANAGING MONOPOLIES AND ADVERSE CONDUCT,
5 QUALITY, AND NATIONAL ECONOMIC IMPACTS IN THAT SEGMENT OF THE STRATEGIC
6 NATIONAL INFRASTRUCTURE KNOWN AS COMMERCIAL HEALTHCARE
7
8

1
2
3 *Be it enacted by the Senate and House of Representatives of the United States of America in*
4 *Congress assembled,*
5 ***SECTION 1. SHORT TITLE; TABLE OF CONTENTS.***
6 *(a) SHORT TITLE. – This act may be cited as the "Healthcare Industries Reform Act" (HIRA).*
7 *(b) TABLE OF CONTENTS. –*

Sec. 1. Short title, table of contents.
Sec. 2. General definitions.
Sec 3. Supersession.
Sec. 4. Overview.
Sec. 5. Effective date.

TITLE I – RULES

Sec. 101. Pricing practices.
Sec. 102. Billing and payment practices.
Sec. 103. Legal practices.
Sec. 104. Facility practices.
Sec. 105 Undocumented and informal practices.
Sec. 106 Insurance practices.
Sec. 107 Audits and certifications.
Sec. 108 Data and technology
Sec. 109 Employee compensation practices.

TITLE II – RESPONSIBILITIES

Sec. 201. Department of Health and Human Services (DHHS).
Sec. 202. General Accounting Office (GAO).
Sec. 203. Internal Revenue Service (IRS).

TITLE III – ENFORCEMENT AND FISCAL PROVISIONS

Sec. 301. Enforcement.
Sec. 302. Independent Accrediting Agency.
Sec. 303. Overview.

8 ***SEC. 2. GENERAL DEFINITIONS.***
9 Reserved.
10 ***SEC. 3. SUPERSESSION.***
11 (1) All laws in conflict with this legislation are hereby declared null and void.
12 ***SEC. 4. OVERVIEW.***
13 (1) Collectively, "Healthcare Providers" such as hospitals, test labs, clinics, practices, physician-

1 practitioners, pharmaceuticals, insurance providers, and other related organizations, are anomalies in
2 the context of U.S. national policy. Healthcare Providers are largely commercial businesses, often
3 monopolies in their markets, and are part of the critical national infrastructure. This is the same
4 situation as the telecommunications, banking, railroads, and electrical utility industries. Yet despite
5 national policy and precedent of enacting effective regulatory controls for critical infrastructure,
6 Healthcare Providers do not have comprehensive, effective regulatory controls. The outcome is a U.S.
7 Healthcare Provider industry that results in roughly three times the cost per citizen and a population
8 one-fourth as healthy than that of comparable modern nations, as of this writing. The negative
9 economic impacts of this situation have become detrimental to the national economy on a scale that
10 requires regulatory intervention as a priority. Specifically, regulatory controls are needed that will:
11 change the focus for healthcare from intervention to prevention; economically reward successful
12 outcomes rather than sheer number of patients treated; set price controls to control costs; establish legal
13 rights that provide more parity in the transactions between individuals and Healthcare Provider
14 monopolies, and reduces risk of litigation as a significant limiting factor in the quality of healthcare.
15 The purpose of this legislation is to establish some of the controls, procedures, and rights under law that
16 are needed.
17 ***SEC. 5. EFFECTIVE DATE.***
18 (1) The provisions in this bill shall become effective twelve months from approval; except for,
19 (2) Tax code changes and IRS responsibilities shall become effective eighteen months from approval.

20 # TITLE I –RULES

21 ***SEC. 101. PRICING PRACTICES***
22 (1) Healthcare Providers shall not earn greater than a 21% profit margin, as calculated according to
23 published Federal General Accounting Office (GAO) approved accounting standards.
24 (2) Healthcare Providers that provide medical treatment to individuals shall charge their customers for
25 medications and materials at not greater than cost plus 2% markup.
26 (3) Healthcare Provider senior management annual compensation, per individual, in all forms, shall not
27 exceed in total aggregate value an amount more than 50 times the lowest salary paid to a full-time
28 employee of the healthcare provider organization, or a limit of $500,000 dollars, whichever is the lesser
29 amount. Reimbursement of reasonable travel costs are not considered compensation for the purpose of
30 this provision.
31 (3) Hospitals shall not pass costs or fees for indigent care to other patients or amortize it into rate

structures. However, hospitals can charge the actual cost of medications and materials to medicare, and claim 50% of fully burdened labor cost as charitable contributions for tax purposes.

(4) Healthcare Providers that provide medical treatment to individuals shall not charge more than the applicable maximum allowable price for services or procedures published by the Federal Department of Health and Human Services (DHHS).

(5) Insurance companies shall not establish reasonable or customary prices for treatments, procedures, or any other service or materials offered by Healthcare Providers. Instead, insurance companies are permitted to establish uniform reimbursement percentages for selected services or procedures, and to establish those medical facilities or providers excluded from plan coverage for reason of pricing violations or medical performance, and are encouraged to evolve new customized individual services as a "trusted advisor" in areas such as explaining treatment options, assisting with health care advance directives and even providing limited health care agents of last resort.

SEC. 102. BILLING AND PAYMENT PRACTICES

(1) The medical facility or provider with whom an individual originally requests and accepts service for a health event shall be known as the capstone provider. The capstone provider shall provide integrated billing to the individual that includes all subordinate subcontracted services such as consulting physicians, lab tests, surgical facilities or staff, or any other cost incurred due to the capstone provider's direction, request, or treatment for the specific health event.. The format of a capstone bill shall comply with the format and standards published by the DHHS.

(2) Hospital admission always establishes a new health event such that a hospital is always a capstone provider for any in-patient from the time of admission until the time of discharge.

(3) Capstone providers may charge a one-time fee per health event to each subordinate provider for processing subordinate provider charges into the integrated bill and handling disbursement of received payment. Such fee shall be limited to an amount published by the Federal DHHS. The capstone provider shall disburse partial payments received for bills equally by percentage to all billing providers.

(4) For any health event served by a capstone provider, an individual shall have no pecuniary liability or financial obligation to pay any costs billed separately from the capstone provider bill. Nor may separate bills be turned-over to collection agencies or for judicial collection remedies. This right shall not be waived or assignable by the individual.

(5) Healthcare Providers that provide medical treatment to individuals are permitted to provide in-patients with homeopathic, non-traditional, and other ancillary services that can reasonably be assumed to contribute to the psychological aspect of healing, pain management, or wellness. Examples include

1 chaplain services, acupuncture, and massage. When such services are requested by the in-patient
2 customer, the medical facility or provider is permitted to provide, and bill for these services, at the fully
3 burdened labor rate calculated with no more than 10% profit margin. Insurance companies shall not
4 disallow such costs for payment except if in possession of clear evidence of fraud.
5 ***SEC. 103. TERMS OF SERVICE PRACTICES***
6 (1) Healthcare Providers shall not require a customer signature on any document waiving legal rights,
7 granting intellectual property rights, with binding financial provisions, or releasing the provider from
8 some or all liability, as a precondition for providing medical service. A customer has the right to decline
9 signing any document as pre-conditional for medical service, except for documents to record medical
10 ailments, symptoms, conditions, or history, to validate identity, to identify who has financial obligation
11 for requested services, or to record explanations (but not the understanding thereof) to the customer.
12 (2) Except for reasons allowed by other provisions in this legislation, Healthcare Providers that provide
13 medical treatment to individuals shall not deny services on the basis of age (except age specific
14 services), gender (except gender specific services), race, religion, political affiliation, social affiliation,
15 nationality, or socioeconomic disadvantage.
16 (3) Healthcare Providers that provide medical treatment to individuals are permitted to deny medical
17 service to any conscious, rational individual arriving for medical service by their own means, who does
18 not provide valid proof of identity if requested to do so by medical personnel.
19 (4) Healthcare Providers that provide medical treatment to individuals are permitted to decline to
20 provide services in entirety to individuals when 102% or more of pre-established service capacity is
21 already in use. Capacity may be established at either a clinic or overall facility basis, or combination of
22 both. However, Healthcare Providers are required to provide services beyond capacity when requested
23 by governor, mayor, or head of a law enforcement agency for reason of natural disaster or mass casualty
24 situation.
25 (5) Healthcare Providers that provide medical treatment to individuals are permitted to decline to
26 provide services in entirety to individuals not of human origin or of familiar biology, and individuals
27 with unfamiliar intentionally engineered technological components to their physiology.
28 (6) Healthcare Providers that provide medical treatment to individuals are permitted to decline to
29 provide services in entirety to unrestrained individuals exhibiting signs of anger or violence deemed by
30 medical facility or provider to be a danger to others.
31 (7) Healthcare Providers that provide medical treatment to individuals are permitted to decline to
32 provide services in entirety to customers with overdue debt to the medical facility or provider

1 exceeding $250,000 US dollars and overdue by more than 380 days.
2 (8) Healthcare Providers that provide medical treatment to individuals, that do not specialize in
3 substance abuse, and that use biometric technology for identity verification, may deny service to an
4 individual known to be a chronic substance abuser/addict because of diagnosis as such within the prior
5 nine months.
6 (9) Healthcare Providers using biometric technology are permitted to interface identity data to law
7 enforcement systems in real time, for a fee to cover costs, and provided that data in transit and at rest is
8 both encrypted and two-person access controlled. Authority to allow such interface resides solely with
9 the highest ranking individual within the healthcare provider organization.
10 (10) Healthcare Providers that provide medical treatment to individuals shall provide new customers
11 with a one-page summary of their performance data including death rates, malpractice rates, infection
12 rates, and cost ranking in comparison to other providers in their region. This summary shall be provided
13 before services are rendered. The DHHS shall establish a standard format for the summary, define
14 regional boundaries, and establish cost rankings.
15 (11) Healthcare Providers shall not, either directly or through proxies of any type, collect, store,
16 analyze, purchase, or traffic in, the genetic material or genetic code of an individual without the express
17 non-coerced written permission of the individual.
18 (12) Healthcare Providers shall not implant in an individual any technology having the purpose or
19 capability of geolocation, or access to signals within the brain or central nervous system via remote
20 access.
21 ***SEC. 104. LEGAL PRACTICES***
22 (1) Healthcare Providers are not legally liable for the consequences of denying service when the basis
23 of denial is a provision in this legislation.
24 (2) A Healthcare Provider shall not file a lien against the property or assets of a customer.
25 (3) It shall be a felony crime for a medical facility or provider to withhold, conceal, or misrepresent the
26 cause of a death, it's true location, and attending personnel, to the health care agent or immediate family
27 of the deceased. Misrepresentation includes arranging for an individual for whom death is known to be
28 imminent to be in transit or sent to another department, test lab, or provider for the purpose of
29 convenience or avoiding liability or blame. The senior management of a medical facility or practice
30 shall be held to have personal liability for punitive financial penalties for violations of this provision.
31 (4) Healthcare Providers that provide medical treatment to individuals shall have the opportunity for
32 Federal DHHS independent third-party review of cases resulting in death or adverse outcomes.

1 Favorable findings from such review shall be deemed a finding of “no wrongful civil liability” in any
2 judicial or arbitration proceeding.
3 ***SEC. 105. FACILITY PRACTICES***
4 (1) Medical facilities may extend in-patient service to include an individual's home as a virtual facility
5 extension when the means for data telemetry and telemedicine presence are provided to the individual
6 at no cost to the individual, physicians are trained and have time available for tele-medical activity, a
7 caregiver is trained and willing to perform minor medical tasks for the individual, and provided no
8 medications restricted under the 1970 Uniform Controlled Substances Act (CSA) are required. Medical
9 facilities choosing to extend their facility capacity in this manner shall be entitled to a tax credit equal
10 to two times the cost of providing such service.
11 ***SEC. 106. UNDOCUMENTED AND INFORMAL PRACTICES***
12 (1) Medical facilities shall not “repatriate” comatose or otherwise critically ill customers to another
13 nation, state, county, or other healthcare provider without the written consent of a verified family
14 member, and from the receiving medical facility or healthcare provider.
15 (2) Healthcare providers shall not use implied consent, negative polling, or any other method where a
16 customer is assumed to agree or approve or request by virtue of inaction.
17 ***SEC. 107. INSURANCE PRACTICES***
18 Reserved.
19 ***SEC. 108. AUDIT AND CERTIFICATION PRACTICES***
20 Reserved.
21 ***SEC. 109. DATA PRACTICES***
22 Reserved.
23 ***SEC. 110. EMPLOYEE PRACTICES***
24 (1) Medical facilities shall not offload their costs for basic support services to employees. For example;
25 employees shall not be required to clean medical tools or work clothing at home or at their expense.
26 Individual employees lack specialized equipment, and standardized levels of quality needed to ensure
27 infection control and such situations shall be construed in judicial and arbitration proceedings as an
28 employer punitive action against the employee, without cause or means of appeal, where compensation
29 is decreased relative to work.
30 ***SEC. 111. CUSTOMER RIGHTS***
31 Reserved.
32

TITLE II – RESPONSIBILITIES

SEC. 201. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

(1) The Federal Department of Health and Human Services (DHHS) shall be responsible to:

(a) Establish a department of medical pricing which shall establish regions and the maximum allowable price for most medical services, treatments, and testing, in those defined regions.

(b) Publish a national standard format for capstone provider billing. DHHS shall employ human factors engineering experts and customer focus groups to ensure the most "customer-friendly" and understandable format possible. Itemization shall include facility, labor, materials, and medications.

(c) Establish and publish the allowable service fee per healthcare event that a capstone billing provider may charge each subordinate provider for integrating the subordinate provider customer charges into the capstone bill and for managing payment disbursements.

(d) Establish a standard format for the Healthcare Provider one-page summary, define regional boundaries, and establish cost standards for ranking purposes.

(e) Establish regional physician teams (RPTR) to review medical cases resulting in death or adverse outcomes for which Healthcare Providers request review. If review of the case reveals a reasonable probability of proper process, treatment, decisions, and care the RPTR will issue a letter of "no wrongful liability". If review of the case reveals a reasonable probability of improper, unethical, or unlawful action or inaction being causal to the death or adverse outcome the RPTR will issue a letter of "wrongful liability" explaining. The RPTR may also issue a letter of "neutrality" when causality is unclear. A letter of "no wrongful liability" for a case relieves the medical facility or provider of civil or pecuniary liability, and requires a higher standard for evidentiary proof be met as a precondition for judicial action.

(f) Establish staffing, procedures and infrastructure for receiving and processing of consumer complaints about Healthcare Provider violations of this legislation.

(g) Establish staffing, procedures and infrastructure for compliance assistance and for investigation and enforcement of this legislation.

SEC. 202. GENERAL ACCOUNTING OFFICE (GAO)

(1) The Federal Government Accounting Office shall be responsible to:

(a) Establish standards for annual audits of Healthcare Provider master pricing, and shall conduct random inspections for compliance.

SEC. 203. INTERNAL REVENUE SERVICE (IRS)

(1) The Federal Internal Revenue Service (IRS) shall be responsible to:

(a) Implement changes to tax forms and procedures as required.

TITLE II – ENFORCEMENT AND FISCAL PROVISIONS

SEC. 301. ENFORCEMENT

(1) The DHHS shall have primary responsibility to enforce the provisions of this legislation, and to do so;

(a) Shall maintain a staff of Special Agents to inspect, investigate, and enforce the provisions of this legislation.

(b) The DHHS Special Agents shall be entitled to enter the premises of any healthcare provider at any time, to have unlimited access to any person, area, computer system, record, electronic device (including any item brought onto the premises by employees, customers, contractors, suppliers, or visitors), and authority to temporarily suspend or revoke any organization or individual accreditation or certification of any kind, any service, practice or operation, or the entire business, or to impose corrective actions, retraining, or compensatory taxes as provided for by this legislation or U.S. tax code, for violations of this legislation.

SEC. 301. CORRECTIVE AND COMPENSATORY REMEDIES

(1) The DHHS shall have primary responsibility to enforce the provisions of this legislation; Healthcare Providers shall not earn greater than a 21% profit margin. Exceeding this limit shall require payment of a tax for the negative impact on society by a key national infrastructure provider equal to two times the amount of profit earned that is over 21%

SEC. 302. FISCAL PROVISIONS

(1) The funding to perform the responsibilities required by this legislation shall come from the compensatory taxes received due to the requirements in this legislation. The scope and scale of responsibilities performed shall be scaled to the amount of funding received.