Accountable Capitalism in Healthcare

A Bipartisan Framework for Stability, Access, and Sustainable Innovation

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SECTION 1 – PURPOSE AND POLICY INTENT

SUMMARY

This proposal introduces a legislative framework to reform the U.S. health insurance industry by decoupling healthcare performance from speculative stock market incentives and embedding structural accountability through corporate governance reform, public reporting, and outcome-based oversight.

It provides universal baseline coverage for essential services, while preserving and enhancing private competition. By transitioning insurance entities into Public Benefit Corporations (PBCs) through a phased regulatory process, the plan realigns industry incentives with public health goals.

This policy initiative is designed to:

- Improve health outcomes and reduce systemic inequity
- Ensure fiscal sustainability by eliminating inefficiency and abuse
- Protect consumer choice and private enterprise
- Offer phased implementation to minimize disruption
- Introduce a legally enforceable mission-driven model for insurers
- Minimize resistance from affected stakeholders through transition funding, tax neutrality, and innovation incentives

Legal Objective:

To amend Title 42 of the U.S. Code (Public Health and Welfare), Title 26 (Internal Revenue Code), and relevant securities law statutes to accommodate the creation of PBC status for major insurers, establish baseline coverage entitlements, and create the Federal Health Utility Board for regulatory oversight.

Financial Objective:

To be revenue-neutral or positive over 10 years via:

- Waste reduction through MLR enforcement
- Reallocation of existing subsidies

- Penalties for non-compliance
- Growth incentives for compliance-aligned entities

Implementation Objective:

To be phased over a five-year period with pilot programs, voluntary early adoption, and full enforcement mechanisms beginning in year six.

SECTION 2 – Transition to Public Benefit Corporation (PBC) Model

Policy Summary

This section mandates a phased transition for all health insurance carriers operating in the fully-insured individual and group markets from publicly traded corporate entities to privately held Public Benefit Corporations (PBCs), governed by amended standards under the Public Benefit Corporation provisions of Delaware General Corporation Law (§ 362-368), and equivalent state statutes.

Objective:

To remove perverse financial incentives created by shareholder primacy and embed a legal obligation to prioritize health outcomes, access, and equity within corporate governance structures.

A. Statutory Requirements

(1) PBC Eligibility and Compliance

- All insurers with 1M+ enrolled lives or $1B+ annual revenue must recharter as PBCs within a five-year period.
- Applicable statutes include amendments to:
    - **42 U.S. Code § 300gg–91** – Definitions
    - **15 U.S. Code § 78l** – Registration of securities

- **26 U.S. Code § 501** – Corporate status tax clarifications

(2) PBC Mandate Includes:

- A declared public mission (e.g., reducing health disparities, increasing rural access, improving outcomes)
- Annual public reporting on mission fulfillment and impact metrics
- Board-level oversight committee on mission compliance
- CEO certification of alignment with public benefit metrics, filed with the SEC and Department of Health and Human Services (HHS)

B. Delisting Protocols

(1) SEC Coordination

- Within 180 days of passage, the SEC will establish compliance pathways for delisting health insurers from NYSE, Nasdaq, and other exchanges.
- Voluntary early adopters will be granted expedited SEC review for modified registration status.

(2) Delisting Deadlines

- Year 1–2: Voluntary early adoption (incentivized)
- Year 3–4: Mandated transition for firms with >$5B market cap
- Year 5: All applicable entities must comply or face structured divestiture

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C. Economic Offsets and Incentives

(1) Healthcare Innovation Compact (HIC):

- A $50B fund over 10 years will support capital restructuring, compliance auditing, and systems integration
- Managed by a new division within HHS, with performance-based disbursements

(2) Tax Incentives:

- Temporary reduction in corporate tax liability (up to 15%) for companies achieving early PBC rechartering and exceeding public mission benchmarks
- Bonus depreciation allowance for infrastructure, health tech, and community reinvestment initiatives

(3) Exemptions and Carve-Outs:

- Subsidiaries not engaged in core health insurance operations may retain publicly traded status
- Certain employer self-funded plans exempt under ERISA are not subject to rechartering but may opt in

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D. Enforcement and Oversight

- The **Federal Health Utility Board (see Section 6)** will certify compliance, conduct audits, and refer violations to DOJ or SEC.
- Failure to recharter by statutory deadline will result in revocation of license to operate in the federally regulated market, subject to appeal.

Framing Benefits

Progressive Alignment:

- Ends “shareholder-first” insurance culture
- Legally binds corporate mission to public good
- Opens pathways for systemic reform

Conservative Alignment:

- Preserves private ownership and competition
- Reduces micromanagement via self-regulating charter structure
- Encourages employee and community-based ownership

Stakeholder Alignment:

- Protects enterprise value through phased, incentive-based restructuring

- Minimizes financial shock through offsets and transition support
- Enhances public trust and future-proofing of business models

SECTION 3 – Universal Baseline Coverage

Policy Summary

This section establishes a publicly funded, universally available baseline health insurance plan that guarantees access to essential medical services for all U.S. citizens and legal residents. It serves as a national health safety net, enabling individuals to access care without dependence on employer-based coverage or private insurance affordability.

This baseline is designed as a "**floor, not a ceiling"**—allowing consumers to purchase supplemental or enhanced private coverage at their discretion.

A. Coverage Scope and Benefits

(1) Universal Baseline Coverage (UBC) includes, at minimum:

- Primary care (preventive and chronic)
- Emergency medical services
- Behavioral and mental health treatment
- Basic prescription drug access
- Maternity and pediatric care
- Diagnostic testing and preventive screenings

(2) Optional Supplemental Coverage (OSC):

- Individuals or employers may purchase supplemental or enhanced coverage from private insurers

- Private insurers may offer value-added plans with faster access, wider networks, luxury services, or additional wellness programs

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B. Legal Foundation

Amend or add new sections to the following titles of the U.S. Code:

- **42 U.S.C. § 1395 (Medicare)** – New subpart for Universal Baseline Plan
- **42 U.S.C. § 300gg (Public Health Service Act)** – Mandated guaranteed issue provisions
- **26 U.S.C. § 36B** – Expanded and simplified premium assistance tax credits

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C. Funding Mechanisms

(1) Baseline Coverage Fund (BCF):

- Federally funded via a mix of:
    - Reallocated ACA subsidies and tax credits
    - Revenue from 90%+ MLR enforcement penalties (Section 4)
    - A modest healthcare value-added fee (HVAF) applied to insurer profits above MLR thresholds
    - Employer coverage offset payments (opt-out support)

(2) Fiscal Guardrails:

- Total outlay capped at a % of GDP with automatic spending reviews every 3 years
- CBO scoring required before final implementation phase

D. State-Based Flexibility and Federal Implementation

(1) State Partnership Option (SPO):

- States may administer the Universal Baseline Coverage program locally if they meet or exceed federal standards

- Grants available for infrastructure and integration
- Federal fallback plan available in states that opt out

(2) Timeline:

- Year 1: Pilot in 5 states
- Year 2–3: Gradual national expansion
- Year 4: Full federal availability
- Year 5: State partnership phase-in complete

E. Individual Participation and Freedom

- Enrollment is automatic, with opt-out allowed for individuals with equivalent or superior coverage
- UBC functions as default fallback during coverage loss (job loss, transitions, etc.)
- No individual mandate penalties
- Private plans remain legal, profitable, and encouraged to compete on value

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Framing Benefits

Progressive Alignment:

- Universal access to core care regardless of income or employment
- Reduces racial, rural, and economic disparities in access
- Establishes healthcare as a human right baseline

Conservative Alignment:

- Maintains competition and consumer choice
- Encourages individual responsibility to upgrade
- Reduces hidden ER taxes and job lock distortion

Stakeholder Alignment:

- Private insurers gain guaranteed market participation at baseline level
- Supplemental plans allow revenue generation beyond UBC
- Employers may offload baseline costs legally while offering high-tier options

SECTION 4 – Enhanced Medical Loss Ratio (MLR) Enforcement

Policy Summary

This section mandates that all qualified health insurance plans operating in the U.S. maintain a Medical Loss Ratio (MLR) of **no less than 90%**, ensuring that the vast majority of premium income is used for actual medical services, not administrative overhead or executive compensation.

This provision builds on the Affordable Care Act's MLR rules and enhances enforcement through mandatory audits, transparency reporting, and public rebates.

A. Legal Requirements

(1) MLR Floor Adjustment:

- All plans—individual, small group, large group—must maintain an MLR of ≥**90%** annually
- Insurers failing to meet this threshold must issue rebates equal to the difference

(2) Applicable Statutes to Amend or Add:

- **42 U.S.C. § 300gg–18** (Medical Loss Ratios under the ACA)
- **26 U.S.C. § 833** (special rules for Blue Cross/Blue Shield)
- **SEC filing requirements** for financial transparency alignment

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B. Enforcement Structure

(1) Oversight:

- Administered jointly by the Department of Health and Human Services (HHS) and the Federal Health Utility Board (Section 6)
- Mandatory annual audits for plans with over 100,000 members
- Random audits for smaller plans on a rotating basis

(2) Penalties and Remediation:

- Failure to meet MLR:
    - Year 1: Mandatory rebate to consumers + written corrective action plan
    - Year 2: License probation and public posting on HHS compliance registry
    - Year 3: License suspension and forced exit from public markets

(3) Loophole Closure:

- Reclassifies “quality improvement” and “utilization review” under strict definitions
- Caps marketing costs eligible for exemption
- Requires insurers to publish executive bonus and lobbying spend alongside MLR reports

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C. Financial and Market Impact

(1) Consumer Rebates:

- Expected to return ~$10B/year directly to policyholders
- Insurers exceeding 90% may retain tax benefits or earn “Value Steward” status for public recognition

(2) Tax Incentives for High Performers:

- Carriers maintaining ≥92% MLR for 3 consecutive years qualify for a corporate tax credit or innovation grant bonus under the Healthcare Innovation Compact (Section 2.C)

(3) Risk Adjustment:

- HHS to develop MLR variance bands for high-risk regional insurers (e.g., rural, tribal) to avoid market exits

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D. Reporting Requirements

- Annual public disclosure of:
    - Actual MLR % by state and market segment
    - Breakdown of overhead categories (admin, marketing, executive comp)
    - Audit status and findings (if applicable)
- Insurers required to submit MLR compliance documentation with SEC 10-Ks or NAIC filings

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Framing Benefits

Progressive Alignment:

- Ensures the majority of premiums directly benefit patients
- Reduces executive bloat and predatory marketing spend
- Makes financial stewardship a public obligation

Conservative Alignment:

- Reinforces fiscal discipline through guardrails, not bureaucracy
- Preserves free market efficiency while penalizing bad actors
- Replaces complex regulation with clean, outcome-driven metrics

Stakeholder Alignment:

- Incentivizes efficiency and performance, not volume of restrictions
- Creates transparency to build trust without adding operational complexity
- Allows strong performers to gain tax and brand advantages

SECTION 5 – Reform of Executive Compensation Practices

Policy Summary

This section prohibits stock-based compensation for executives at health insurance companies operating within the federally regulated healthcare market. Compensation must instead be tied to patient outcomes, cost containment, and long-term performance metrics aligned with public benefit goals.

This provision addresses the perverse financial incentives that currently reward denial of care, short-term stock manipulation, and cost cutting unrelated to health outcomes.

A. Prohibited Practices

(1) Scope of Ban:

- Executives of insurers rechartered as Public Benefit Corporations (Section 2) may not receive:
    - Stock options
    - Stock grants
    - Performance pay tied to earnings per share (EPS), stock price, or market capitalization
- Applies to:
    - CEO, CFO, COO, General Counsel, and any senior executive earning 10x median company salary
    - Health insurance operations only (subsidiary exemptions noted below)

B. Compensation Guidelines

(1) Permitted Structures:

- Fixed salary within standardized bands indexed to company size
- Annual bonus tied to:
    - Verified patient outcome improvements (e.g., lower readmission rates)
    - Cost containment verified by 90%+ MLR compliance
    - External peer and customer satisfaction review data
- Bonus compensation must be reviewed by an independent Compensation Ethics Committee (CEC)

(2) Subsidiary Carve-Outs:

- Executives working exclusively for non-insurance arms (e.g., technology platforms, data analytics units) are exempt
- Requires proof of functional separation and revenue independence

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C. Legal and Regulatory Basis

- Amend U.S. Code Titles:
    - **26 U.S.C. § 162(m)** – Limit deductibility of executive comp tied to stock
    - **42 U.S.C. § 300gg–92** – New section: Ethical Executive Compensation Compliance
- Empower the **Federal Health Utility Board (Section 6)** to audit pay structures and enforce compliance

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D. Enforcement Measures

(1) Certification & Oversight:

- Annual executive compensation certification required, signed by CEO and attested by third-party CEC
- HHS and FHUB reserve right to publicly flag, fine, or suspend companies with violative structures

(2) Penalties for Violation:

- Reversal of tax deductions for violative pay

- Public fine equal to 200% of misaligned compensation
- Suspension from eligibility for Healthcare Innovation Compact funding or federal contract participation

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E. Alignment and Incentives

(1) Long-Term Leadership Bonus:

- CEOs and executives may receive delayed retention bonuses (5+ year vesting) tied to:
    - Sustained health outcome performance
    - MLR surplus sharing
    - Market stability metrics (e.g., coverage retention, service access rate growth)

(2) Transparency Awards:

- Voluntary publication of full exec pay and metrics will earn “Accountable Enterprise” certification for marketing advantage

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Framing Benefits

Progressive Alignment:

- Eliminates profit-driven perverse incentives that harm patients
- Frees up capital for reinvestment in care delivery
- Makes compensation a tool for public accountability

Conservative Alignment:

- Respects private enterprise autonomy through structural reform
- Promotes earned success based on results, not speculation
- Protects shareholders and pensioners from EPS manipulation

Stakeholder Alignment:

- Keeps executive leadership competitive through incentive redesign—not federal caps
- Provides clear, lawful guidelines with room for performance-based reward
- Reduces reputational risk from excessive executive pay exposure

SECTION 6 – Establishment of the Federal Health Utility Board (FHUB)

Policy Summary

This section creates the **Federal Health Utility Board (FHUB)**, a nonpartisan, independent regulatory and oversight body tasked with ensuring insurer accountability, monitoring compliance with this act, publishing transparency metrics, and guiding structural enforcement of Public Benefit Charter obligations.

FHUB will serve as a "market referee"—not a care manager—mirroring models like the **Federal Reserve**, **SEC**, or **FAA** in structure and independence.

A. Board Structure and Authority

(1) Governance and Appointment:

- FHUB will consist of:
    - **7 commissioners**: nominated by the President, confirmed by the Senate, staggered 7-year terms
    - No more than 4 commissioners may belong to the same political party
- Supported by a professional staff with actuarial, legal, medical, and audit expertise

(2) Authority and Jurisdiction:

- FHUB’s authority spans:
    - Public Benefit Corporation oversight (Section 2)
    - MLR audit enforcement (Section 4)
    - Executive compensation review (Section 5)
    - Public reporting and data publication (Section 6.C)
- Jurisdiction applies to all insurers participating in the federally regulated health insurance market (individual, group, and Medicare Advantage plans)

B. Core Functions

(1) Charter and Outcome Compliance

- Annual review of each insurer’s adherence to its Public Benefit mission
- Verification of health equity, rural access, and health improvement metrics

(2) MLR Oversight and Enforcement

- Review and audit of insurer-reported MLR ratios
- Issue penalties, demand rebates, and certify MLR compliance status

(3) Executive Compensation Audit

- Ensure insurers meet ethical compensation criteria
- Review executive pay alignment with certified performance benchmarks

(4) Public Data Publication

- Maintain a searchable, public database of:
    - MLR performance
    - Patient outcome trends
    - Access disparities
    - Regulatory violations and enforcement actions

(5) Emergency Response Readiness

- Coordinate with HHS, FEMA, and CDC in future national health crises
- Use real-time insurer data to support national resilience planning

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C. Implementation Timeline

Year	Milestone
1	FHUB Commissioners nominated and confirmed; framework published
2	Staff hiring, baseline data gathering begins
3	First audit cycle of top 10 insurers by enrollment
4	Public Benefit enforcement metrics published
5	Full national auditing and enforcement capabilities in effect

D. Legal Establishment

- Add new chapter to **42 U.S.C.** titled: *Chapter 163 – Federal Health Utility Board*
- Empower FHUB under authority similar to:
    - **15 U.S.C. § 78d** (SEC creation)
    - **12 U.S.C. § 241** (Federal Reserve Board creation)
- FHUB commissioners subject to ethics rules, transparency standards, and removal only for cause

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E. Relationship to Other Agencies

- Collaborates with:
    - **HHS** (data sharing and subsidies)
    - **DOJ** (for fraud or antitrust)
    - **SEC** (for delisting support and compensation disclosures)
    - **IRS** (for tax-related enforcement)

Framing Benefits

Progressive Alignment:

- Enforces corporate accountability and mission-driven transparency
- Empowers data-driven reform on disparities and outcomes
- Protects consumers from abuse through public disclosure

Conservative Alignment:

- Prevents bureaucratic overreach by separating oversight from care delivery
- Promotes apolitical governance modeled after proven institutions
- Enhances system stability without federal micromanagement

Stakeholder Alignment:

- Clarifies regulatory expectations to reduce compliance ambiguity
- Encourages strong actors with clean audits and performance recognition
- Avoids legislative whiplash through a consistent, independent authority

SECTION 7 – Enforcement and Compliance Integration

Policy Summary

This section establishes the unified enforcement framework for all provisions within this legislation. It defines the authority, process, penalties, and due process rights applicable to health insurers, executives, and other regulated entities under the Act. It ensures consistency, protects due process, and deters non-compliance through measured yet enforceable consequences.

A. Core Enforcement Agencies and Jurisdictions

(1) Federal Health Utility Board (FHUB):

- Primary authority over compliance auditing, public reporting, and penalty issuance
- Can recommend civil enforcement actions to DOJ or financial oversight to SEC
- Delegates corrective actions and monitors remediation timelines

(2) Department of Health and Human Services (HHS):

- Manages subsidies, public plan disbursements, and integration with Medicare/Medicaid systems
- Collaborates with FHUB on coverage mandates and MLR tracking

(3) Department of Justice (DOJ):

- Prosecutes cases involving intentional fraud, misrepresentation, or executive misconduct
- Enforces revocation of licenses for repeat or criminal violators

(4) Securities and Exchange Commission (SEC):

- Enforces stock delisting compliance and corporate disclosures under Section 2
- Monitors fraudulent compensation practices and financial manipulation

(5) Internal Revenue Service (IRS):

- Enforces tax credit eligibility, clawbacks, and MLR-linked tax penalties
- Audits corporate filings for compensation and structural compliance

B. Penalty Structure

(1) Graduated Enforcement Tiers:

Violation Type	First Offense	Second Offense	Chronic/Willful
MLR <90%	Rebate + Plan Filing	License Warning + Fine	License Suspension
Exec Pay Violation	Forfeiture + Audit	2x Penalty + SEC Flag	DOJ Referral
Charter Noncompliance	Remediation Order	FHUB Oversight Expansion	Charter Revocation
Data Misreporting	Correction + Warning	Public Disclosure	DOJ Investigation
Lobbying Abuse (e.g. self-dealing)	Disclosure Required	Disqualification from Innovation Fund	Public Sanction

(2) Civil Penalties:

- Civil fines up to **$25M per major violation**
- Consumer restitution for financial or health harms tied to fraud
- Public enforcement registry published by FHUB quarterly

C. Appeals and Remediation

(1) Administrative Appeals:

- Insurers or executives may appeal enforcement decisions to FHUB Administrative Law Panel within 60 days
- Emergency suspensions subject to expedited review within 10 business days

(2) Corrective Action Plans (CAPs):

- FHUB may mandate formal CAPs for violators in lieu of immediate penalty
- Plans must include metrics, timetables, and quarterly reporting

(3) Public Participation:

- Citizens or whistleblowers may file enforcement petitions or comment on regulatory violations

- False complaints penalized under existing federal law to prevent abuse

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D. Enforcement Transparency

- All enforcement actions logged in a **Public Compliance Dashboard** maintained by FHUB
- Dashboard will include:
    - Violations by type, outcome, and timeline
    - Pending appeals
    - Industry compliance benchmarks

Framing Benefits

Progressive Alignment:

- Enforces accountability without excessive bureaucracy
- Protects patients from negligent or predatory practices
- Provides legal pathways for justice and public oversight

Conservative Alignment:

- Streamlined system relies on independent review, not bloated federal departments
- Targets bad actors without punishing compliant businesses
- Limits regulatory sprawl by consolidating enforcement in FHUB

Stakeholder Alignment:

- Clear compliance rules reduce uncertainty
- Graduated penalties prevent punitive overreach
- Appeals system preserves business due process rights

SECTION 8 – Funding Projections and Fiscal Scoring

Policy Summary

This section outlines the funding mechanisms, budgetary offsets, and fiscal assumptions that support the proposal's implementation. It is designed to be **budget-neutral or revenue-positive over a 10-year window**, consistent with Congressional Budget Office (CBO) scoring methodology. All funding mechanisms emphasize sustainability, efficiency, and reinvestment over taxation.

A. Federal Cost Estimates (10-Year Outlook)

Component	Estimated Cost	Notes
Universal Baseline Coverage (UBC)	$2.3T	Net cost after consolidation of subsidies and emergency care
Healthcare Innovation Compact	$50B	Includes capital offsets, compliance grants, and tech modernization
Federal Health Utility Board	$4B	Overhead, staffing, and operational systems
Public Reporting & Transparency Systems	$2B	Includes dashboard and API infrastructure
Total Gross Cost	**$2.356T**	Before offsets and savings

B. Offset Mechanisms and Revenue Sources

Source	10-Year Estimate	Notes
Reallocation of ACA Subsidies / Tax Credits	$750B	Sunset legacy subsidies in favor of UBC
Executive Pay Reform & MLR Rebate Recovery	$250B	Based on existing ACA rebate history and new enforcement tier
Healthcare Value-Added Fee (HVAF)*	$400B	Fee applied to insurer profits exceeding 10% margin
Administrative Waste Reduction	$300B	Efficiency gains from MLR rules and compensation limits
Delisting Transition Savings (SEC & compliance reduction)	$100B	Estimated over 10 years
Reduced Emergency Room Subsidies & Medicaid duplicity	$300B	Savings via baseline coverage and reduced uncompensated care
Total Offsets / Revenue	**$2.1T**	

Net Estimated Cost After Offsets:
~$256B over 10 years, or **~$25.6B/year**

Net Cost as % of GDP:
~0.1% annually (well below other federal entitlements)

*Note: HVAF would function like a modest transaction fee, not a consumer tax—targeted at insurers with excess profit margins.

C. Long-Term Savings Projections (20+ Years)

- Lower rates of medical bankruptcy = ↑ productivity, ↓ public assistance
- Higher workforce mobility = ↑ entrepreneurship and small business formation
- Preventive access = ↓ chronic condition treatment costs
- Reduced ER misuse = ↓ state and local health system strain

D. CBO-Ready Structuring

Scoring Strategy:

- All outlays and revenue must be matched with traceable statutory mechanisms
- Net cost kept within reconciliation window thresholds if needed
- Mandatory sunset and reauthorization after 10 years ensures fiscal discipline

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Framing Benefits

Progressive Alignment:

- Equitable funding from inefficiency and over-compensation—not the middle class
- Prioritizes care access without deepening debt

Conservative Alignment:

- Fiscally responsible design avoids major tax hikes
- Net cost <1% of GDP
- CBO-friendly formatting allows procedural flexibility (reconciliation option)

Stakeholder Alignment:

- Predictable capital structure and incentives
- Insurers remain profitable through innovation and value—not denial or margin games
- Transparent fiscal plan reduces opposition from deficit-focused critics

SECTION 9 – Legislative Implementation Path

Policy Summary

This section outlines the legal and procedural route through which the Accountable Capitalism in Healthcare proposal may be enacted. It includes options for standard legislative approval, reconciliation usage, federal-state coordination, and phased implementation timelines.

A. Legislative Vehicle Options

(1) Regular Order (Full Legislative Passage):

- Bill introduced in House and/or Senate
- Reviewed by relevant committees (e.g., Energy & Commerce, HELP, Ways & Means)
- Subject to floor debate, amendments, and 60-vote threshold in Senate
- Best for long-term structural reform with broad coalition

(2) Budget Reconciliation Path:

- Eligible due to:
    - Spending, revenue, and deficit implications
    - Inclusion of mandatory spending (baseline coverage) and revenue offsets (MLR rebates, tax reforms)
- Can bypass Senate filibuster with **51-vote majority**
- Limited to provisions directly impacting budget as interpreted under the Byrd Rule

> Recommendation: **Use reconciliation for Sections 3 (UBC), 4 (MLR), and 8 (Funding)**
> Reserve Sections 2, 5, and 6 for standalone or follow-up bills if needed

B. Implementation Timeline (Years 1–5)

Year	Milestones
Year 1	Enactment of UBC pilot; appointment of FHUB Commissioners; opt-in early adopter insurers begin transition
Year 2	Innovation Compact funding opens; SEC begins delisting support; baseline coverage expands to 10 states
Year 3	Mandatory MLR reporting at 90% threshold; full FHUB audits of top insurers; federal fallback UBC plan launches

Year	Milestones
Year 4	50-state availability of UBC; first exec compensation audits; baseline phase-in of all major insurers into PBC status begins
Year 5	Full enforcement of all provisions; public dashboards active; public benefit scorecard launched

C. Federal-State Partnership Flexibility

(1) State Innovation Option:

- States may submit proposals to:
    - Administer Universal Baseline Coverage directly
    - Implement higher MLR thresholds
    - Expand public mission requirements in PBC charters
- Must demonstrate equivalency or superiority to federal benchmarks

(2) Federal Fallback Model:

- Any state opting out or failing to comply will default to:
    - Federally administered baseline coverage plan
    - Direct HHS oversight for compliance
    - Eligibility for federal infrastructure grants withdrawn

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D. Administrative Infrastructure

(1) Creation of New Bodies:

- Federal Health Utility Board (Section 6)
- Healthcare Innovation Compact Council (under HHS)

(2) Use of Existing Agencies:

- HHS (plan administration, auditing support)
- IRS (tax and subsidy processing)

- SEC (corporate transition and disclosure compliance)
- DOJ (enforcement of violations)

Framing Benefits

Progressive Alignment:

- Rapid rollout prioritizes states and communities most in need
- Federal fallback ensures national consistency

Conservative Alignment:

- Respects state rights and innovation pathways
- Offers reconciliation path to limit procedural conflict

Stakeholder Alignment:

- Predictable and staged timeline eases operational transition
- Allows insurers and employers to plan ahead and build compliant infrastructure

SECTION 10 – Definitions and Statutory References

Policy Summary

This section provides clear, standardized definitions for key terms used throughout the proposal and identifies relevant portions of the U.S. Code to be amended or created. This ensures legal clarity and prepares the proposal for integration into a formal legislative bill.

A. Definitions

Term	Definition
Public Benefit Corporation (PBC)	A for-profit corporation legally obligated to pursue both shareholder value and a specific public mission, with reporting requirements on

Term	Definition
	social/environmental impact
Universal Baseline Coverage (UBC)	A publicly funded health plan offering all U.S. citizens and legal residents access to a core set of essential health services regardless of employment, income, or health status
Supplemental Coverage	Any optional, privately purchased health insurance plan offering services beyond UBC, such as expanded provider networks, premium services, or faster access
Medical Loss Ratio (MLR)	The percentage of premium income a health insurance company spends on actual medical care and health improvement efforts, as opposed to administration, marketing, or profit
Healthcare Innovation Compact (HIC)	A federal funding and support program that provides grants, tax benefits, and capital transition assistance to insurers and states that adopt best practices in reform implementation
Federal Health Utility Board (FHUB)	A nonpartisan, independent oversight entity charged with auditing, enforcing, and publishing compliance metrics across all regulated insurers
Executive Compensation Ethics Committee (CEC)	An internal or third-party committee required to audit and certify compliance with performance-based executive compensation rules under this Act
Healthcare Value-Added Fee (HVAF)	A marginal fee applied to insurance company profits exceeding a regulatory threshold, used to partially fund Universal Baseline Coverage and offset uncompensated care costs
Qualified Health Insurer	Any insurer subject to regulation under this Act due to enrollment size, revenue threshold, or participation in federally regulated markets

B. U.S. Code Statutory References

The following federal laws will be **amended or expanded** to enact this proposal:

Title 42 – Public Health and Welfare

- **§ 300gg–18**: Enhanced MLR rules
- **§ 300gg–91**: Expanded definitions for market eligibility

- **New Chapter: 163 – Federal Health Utility Board**

Title 26 – Internal Revenue Code

- **§ 36B**: Reformed and expanded premium tax credits
- **§ 162(m)**: Executive compensation deductibility limits
- **§ 501**: Clarify PBC treatment under nonprofit and tax-exempt provisions

Title 15 – Securities Law

- **§ 78l**: Registration and delisting of publicly traded insurers
- **§ 78n**: Corporate reporting for PBCs
- **§ 80a**: Investment adviser conflicts in healthcare compensation structures

Title 5 – Administrative Law

- **New Subchapter under § 554**: Appeals and review process for FHUB decisions

C. Statutory Crosswalk Table

Policy Area	Primary U.S. Code Title	Notes
MLR and Coverage Rules	Title 42	Builds on ACA public health provisions
Tax Credits and Compensation	Title 26	Revenue-neutral design and pay reform
Securities Oversight	Title 15	Delisting, reporting, and compensation disclosure
Appeals and Enforcement	Title 5	FHUB adjudication and procedural protections

Framing Benefits

Progressive Alignment:

- Establishes legally enforceable care access, transparency, and equity standards
- Embeds social mission in corporate law structure

Conservative Alignment:

- Respects constitutional boundaries and uses existing federal titles
- Emphasizes clear definitions, limited federal sprawl, and self-regulating incentives

Stakeholder Alignment:

- Provides legal predictability for insurers, executives, investors, and auditors
- Facilitates structured compliance planning and transition budgeting

SECTION 11. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to interfere with the doctor-patient relationship or prohibit the operation of private insurance markets outside of the baseline coverage system.

SECTION 12. SEVERABILITY.

If any provision of this Act is found to be unconstitutional or unenforceable, the remaining provisions shall not be affected and shall remain in full force and effect.