🏛️ Main Street Health Compact Act of 2025

A Bill to establish a comprehensive, fraud-resistant, patient-first healthcare framework to replace the Affordable Care Act, ensure universal access, eliminate denial-based coverage restrictions, and enforce strict cost transparency and anti-gouging protections.

PART I — SHORT TITLE AND PURPOSE

Section 101. Short Title This Act may be cited as the **"Main Street Health Compact Act of 2025."**

Section 102. Purpose The purpose of this Act is to:

- Replace the Affordable Care Act (ACA) with a streamlined, enforceable, patient-first healthcare framework;
- Guarantee universal access to medically recommended care without denial;
- Eliminate price gouging and fraud across all sectors of the healthcare system;
- Establish a public option in underserved markets;
- Expand coverage to include dental, vision, mental health, substance abuse, long-term care, and reproductive health;
- Ensure continuity of coverage in the event of insurer withdrawal;
- Provide small business relief and enforce transparency across all federally funded healthcare entities.

PART II — DEFINITIONS

Section 201. Definitions For purposes of this Act:

- **"ACA"** refers to the Patient Protection and Affordable Care Act (Public Law 111–148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152).
- **"Public Option"** means a federally administered health insurance plan made available under this Act.
- **"Federally Funded Provider"** means any healthcare provider receiving direct or indirect federal reimbursement under this Act.
- **"Medically Recommended Treatment"** means any treatment, procedure, or service recommended by a licensed healthcare provider in accordance with clinical guidelines recognized by the Centers for Medicare & Medicaid Services (CMS).
- **"Essential Medications"** means prescription drugs listed on the CMS Essential Drug List or designated by the Secretary of Health and Human Services.

- **“Underserved Area”** means any county or region with fewer than two active private health insurers offering comprehensive coverage.
- **“Experimental Treatment”** means any investigational or non-standard treatment recommended for a life-threatening condition, as defined by Section 1861 of the Social Security Act.

PART III — TRANSPARENCY AND BILLING REFORM

Section 301. Price Transparency Requirements
(a) All federally funded providers shall publish real-time pricing dashboards for all services, procedures, and medications.
(b) Dashboards shall be publicly accessible and updated quarterly.
(c) Noncompliance shall result in a 12-month suspension of federal reimbursement eligibility.

Section 302. Surprise Billing Ban
(a) No provider may issue a bill for out-of-network services rendered without prior patient consent, except in emergency situations.
(b) Violations shall result in automatic clawbacks and public registry listing.

Section 303. Provider Audit and Anti-Gouging Enforcement
(a) The Inspector General of the Department of Health and Human Services shall conduct quarterly audits of billing patterns.
(b) Providers charging more than 20% above regional benchmarks shall be flagged for review.
(c) Repeat offenders shall be subject to clawbacks, public exposure, and criminal referral under 18 U.S.C. § 1347 (Health Care Fraud).

PART IV — DIRECT FUNDING AND INSURANCE REFORM

Section 401. Elimination of ACA Subsidy Structure
(a) The subsidy framework established under Section 1401 of the Patient Protection and Affordable Care Act is hereby repealed.
(b) All federal funds previously allocated to premium tax credits shall be redirected to direct provider reimbursement under this Act.

Section 402. Direct-to-Provider Payment System
(a) The Secretary of Health and Human Services shall establish a national claims processing system to reimburse providers directly for care delivered to eligible patients.
(b) Reimbursement shall be tied to service delivery, not enrollment or actuarial projections.
(c) Providers shall submit claims electronically using standardized formats defined under 45 CFR § 162.

Section 403. Insurance Administrative Overhead Cap
(a) Any insurer receiving federal funds under this Act shall maintain administrative overhead below 10% of total expenditures.

(b) Insurers exceeding this threshold shall be subject to clawbacks and public registry listing.
(c) The Secretary shall publish quarterly reports on insurer compliance.

Section 404. Denial Rate Audits and Enforcement
(a) Insurers shall submit denial rate data to the Claims Review Board established under Section 601.
(b) Insurers with denial rates exceeding 5% for medically recommended treatments shall be flagged for audit.
(c) Upon three confirmed violations, insurers shall lose eligibility for federal participation for a period of 12 months.

Section 405. Whistleblower Protections and Incentives
(a) Any individual who reports fraudulent billing, denial manipulation, or pricing abuse shall be protected under 42 U.S. Code § 300gg–22.
(b) Verified reports resulting in clawbacks shall entitle whistleblowers to 10% of recovered funds, capped at $250,000 per case.

PART V — PUBLIC OPTION AND UNIVERSAL COVERAGE

Section 501. Establishment of Public Option
(a) The Secretary shall establish a federally administered public health insurance plan available to all residents of the United States.
(b) In counties with fewer than two private insurers offering comprehensive coverage, the public option shall be automatically deployed.
(c) The public option shall include coverage for all services defined under Section 1302(b) of the ACA, plus additional provisions under this Act.

Section 502. Auto-Enrollment and Opt-Out Rights
(a) Uninsured individuals shall be auto-enrolled in the public option unless they opt out in writing.
(b) No penalties shall apply for opting out or switching plans.

Section 503. Local Administration and Oversight
(a) Public option plans shall be administered locally by regional boards appointed by the Secretary.
(b) Boards shall include clinicians, patient advocates, and compliance officers.
(c) All public option claims shall be subject to real-time audit and fraud flagging.

Section 504. Coverage Continuity Guarantee
(a) In the event of insurer withdrawal from any market, the public option shall expand to ensure uninterrupted coverage.
(b) The federal claims system shall activate direct-pay contracts with providers in affected areas.
(c) No patient shall experience a lapse in coverage due to insurer exit.

PART VI — DENIAL-FREE CARE AND EXPERIMENTAL TREATMENT PROTECTIONS

Section 601. Denial-Free Care Mandate
(a) No insurer, provider network, or third-party administrator receiving federal funds under this Act may deny coverage for any medically recommended treatment.
(b) “Medically recommended” shall be defined as any treatment documented by a licensed provider and supported by clinical guidelines recognized by CMS, NIH, or the U.S. Preventive Services Task Force.
(c) Denials issued in violation of this section shall trigger automatic clawbacks and public registry listing.

Section 602. Experimental Treatment Coverage for Life-Threatening Conditions
(a) Any investigational or non-standard treatment recommended for a life-threatening condition shall be covered under this Act.
(b) “Life-threatening” shall include terminal diagnoses, organ failure, late-stage cancer, and other conditions defined under Section 1861 of the Social Security Act.
(c) Providers shall submit documentation of clinical rationale and patient consent.
(d) Payment shall proceed without delay; flagged cases may be reviewed post-payment by the Claims Review Board.

Section 603. Post-Denial Cost Accountability
(a) If any treatment is denied after delivery, the provider shall absorb the cost.
(b) Patients shall not be billed for any denied service covered under this Act.
(c) Providers passing denied costs to patients shall face clawbacks and 12-month suspension from federal reimbursement eligibility.

Section 604. Claims Review Board
(a) The Secretary shall establish an independent Claims Review Board composed of licensed clinicians, patient advocates, and fraud analysts.
(b) The Board shall evaluate flagged claims, denial patterns, and audit anomalies.
(c) Findings shall be published quarterly and integrated into the public dashboard.

Section 605. Denial Reporting Portal
(a) The Secretary shall maintain a public-facing portal for patients to report denials, delays, or billing manipulation.
(b) Verified reports shall trigger automatic audit review and whistleblower protections under Section 405.

PART VII — COMPREHENSIVE COVERAGE EXPANSIONS

Section 701. Mental Health Parity and Access
(a) All plans under this Act shall provide mental health coverage equal to physical health coverage, as required under 42 U.S.C. § 300gg–26.

(b) Crisis care, suicide prevention, and teletherapy shall be covered with zero out-of-pocket cost.
(c) Grants shall be issued to school districts and community clinics to expand mental health access.

Section 702. Substance Abuse Treatment and Recovery
(a) All plans shall cover addiction treatment, recovery services, and Medication-Assisted Treatment (MAT).
(b) Community-based recovery programs shall be eligible for federal grants.
(c) All substance abuse expenditures shall be logged in the public audit dashboard.

Section 703. Veteran-Specific Provisions
(a) Veterans shall be fast-tracked into public option plans upon request.
(b) Care coordination between VA facilities and local providers shall be funded and enforced.
(c) No denial shall be permitted for service-connected conditions, regardless of provider network.

Section 704. Dental and Vision Coverage
(a) All public option plans shall include dental and vision coverage.
(b) Preventive services (cleanings, exams, basic lenses) shall be zero out-of-pocket.
(c) Medically necessary procedures shall be covered in full.

Section 705. Long-Term Care Integration
(a) Coverage shall include home-based care, assisted living, and skilled nursing.
(b) Family caregivers shall be eligible for stipends and training grants.
(c) Facilities shall be subject to fraud audits and public reporting.

Section 706. Reproductive Health Protections
(a) Coverage shall include contraception, prenatal care, fertility services, and menopause management.
(b) Preventive OB/GYN services shall be zero out-of-pocket.
(c) No denial or delay shall be permitted for medically recommended reproductive procedures.

PART VIII — PHARMACEUTICAL REFORM, SMALL BUSINESS RELIEF, AND ENFORCEMENT INFRASTRUCTURE

Section 801. Pharmaceutical Pricing Reform
(a) The Secretary shall establish federal price ceilings for all essential medications reimbursed under this Act, indexed to the median price across OECD nations.
(b) No manufacturer may engage in pay-for-delay agreements or patent extensions beyond the original FDA approval window.
(c) The Secretary shall authorize bulk purchasing agreements for public option plans and eligible clinics.
(d) All drug prices shall be published in a real-time dashboard accessible to the public.

Section 802. Small Business Health Relief
(a) Employers with fewer than 50 full-time employees shall be eligible for scaled tax credits for offering health coverage.

(b) Credits shall be indexed to wage levels and coverage quality.
(c) The Secretary shall establish group purchasing pools to allow small businesses to negotiate rates collectively.
(d) A streamlined compliance portal shall be created to simplify reporting and enrollment.

Section 803. Enforcement Infrastructure
(a) The Office of the Inspector General (OIG) shall oversee enforcement of all provisions under this Act.
(b) The Secretary shall establish a centralized audit system using AI-driven anomaly detection to flag fraud, gouging, and denial manipulation.
(c) All flagged entities shall be subject to clawbacks, public exposure, and criminal referral under 18 U.S.C. § 1347.
(d) A public dashboard shall display:

- All federal healthcare expenditures
- All flagged providers, insurers, and vendors
- All clawback actions and enforcement outcomes

PART IX — TRANSITION AND REPEAL

Section 901. Transition Timeline
(a) All provisions of this Act shall be implemented within six months of enactment.
(b) The Secretary shall publish monthly progress reports on:

- Public option deployment
- Claims system activation
- Audit infrastructure readiness
- Coverage continuity metrics

Section 902. Repeal of Conflicting Provisions
(a) The following sections of the ACA are hereby repealed:

- Section 1401 (Premium Tax Credits)
- Section 1302(b) (Essential Health Benefits, as redefined under this Act)
- Section 1331 (Basic Health Program)

  (b) Any provision of federal law in conflict with this Act shall be superseded to the extent of such conflict.

Section 903. Rulemaking Authority
(a) The Secretary shall have authority to promulgate regulations necessary to carry out the provisions of this Act.

(b) All regulations shall be subject to public comment and review under the Administrative Procedure Act (5 U.S.C. § 551 et seq.).

PART X — SEVERABILITY AND EFFECTIVE DATE

Section 1001. Severability If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of its provisions shall not be affected.

Section 1002. Effective Date This Act shall take effect 30 days after enactment, with full implementation required within six months.