TITLE III—UNSTACK HEALTH CARE

SEC. 301. FINDINGS AND PURPOSE.

(a) Findings.—Congress finds that—

(1) the United States spends more per person on health care than any other industrialized nation, yet tens of millions of people remain uninsured or underinsured and health outcomes often lag behind those of peer nations;

(2) health care prices in the United States have risen faster than wages and general inflation for many families, employers, and public programs, placing growing pressure on household budgets and the general welfare of the United States;

(3) prices for the same health care items and services vary widely across payers, providers, and geographic areas in ways that often bear little relation to quality, outcomes, or underlying cost;

(4) concentration, consolidation, vertical integration, and market power among hospitals, physician groups, insurers, pharmacy benefit managers, drug companies, and other health care intermediaries have reduced competition and increased the ability of dominant firms to demand excessive prices and impose unfair terms;

(5) excessive commercial health care prices are a principal driver of national health care spending growth, suppress wages, strain employer-sponsored coverage, and increase Federal and State fiscal burdens;

(6) most patients are unable to shop effectively for health care on the basis of price because medical needs are often urgent, prices are opaque, networks are restrictive, billing practices are confusing, and consumers lack meaningful bargaining power;

(7) as a result, many Americans can do little more than watch helplessly as premiums, deductibles, copayments, coinsurance, facility fees, drug prices, and other health care costs rise year after year; and

(8) a reasonable person could conclude from these conditions that the health care system is stacked against them.

(b) Purpose.—The purposes of this title are—

(1) to promote the general welfare of the United States by establishing universal health care;

(2) to restrain consolidation, profiteering, and other practices that inflate health care prices and prevent people from obtaining needed care; and

(3) to unstack the health care system.

SEC. 302. ESTABLISHING A PRICE CEILING ON MEDICAL SERVICES.

(a) Congress finds that—

(1) prices for identical health care items and services vary widely across payers in the United States;

(2) such price variation is primarily driven by market concentration, consolidation, and price discrimination, rather than differences in quality or outcomes;

(3) excessive commercial prices are a principal driver of national health care spending growth and employer health costs; and

(4) establishing a uniform maximum lawful price for covered health care items and services across all payers will reduce costs, improve equity, and preserve patient choice of provider.

(b) Definitions.—In this section:

(1) Ceiling price.—The term "ceiling price" means, with respect to a health care item or service, the Medicare reimbursement rate multiplied by 1.20, exclusive of any tax, duty, fee, or other charge that is imposed for remittance to a Federal, State, or local government with respect to the furnishing of, or payment for, such item or service.

(2) Health care item or service.—The term "health care item or service" means any item or service for medical, surgical, behavioral, preventive, rehabilitative, habilitative, diagnostic, therapeutic, palliative, maternity, or supportive care.

(3) Medicare reimbursement rate.—The term "Medicare reimbursement rate" means, with respect to a health care item or service—

(A) prior to January 1, 2028, the amount that would be payable for such item or service if furnished to an individual entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title pursuant to—

(i) section 1848 of the Social Security Act (42 U.S.C. 1395w-4);

(ii) section 1833(t) of such Act (42 U.S.C. 1395l(t));

(iii) section 1886(d) of such Act (42 U.S.C. 1395ww(d)); or

(iv) any other applicable payment system under title XVIII of such Act (42 U.S.C. 1395 et seq.);

(B) on and after January 1, 2028, the amount payable under the national fee schedule established under section 326(d)(1)(A); and

(C) if no amount is clearly established under subparagraph (A) or (B), an amount established by the Secretary using a comparable Federal health care payment methodology.

(4) Payer.—The term “payer” means any group health plan, health insurance issuer, employer-sponsored plan, plans or coverage subject to the Employee Retirement Income Security Act of 1974, third party administrator, governmental payer, or other entity that finances or reimburses health care items or services.

(5) Provider.—The term “provider” means any hospital, physician, practitioner, facility, or other person or entity that furnishes health care items or services.

(6) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.

(c) Establishment and review of Medicare reimbursement rates.—

(1) In general.—The Secretary shall ensure that a Medicare reimbursement rate is established and in effect for all health care items and services for purposes of this title.

(2) Pediatric and children’s services.—In carrying out paragraph (1), the Secretary shall affirmatively review and, as necessary, establish or update Medicare reimbursement rates for health care items and services primarily or disproportionately furnished to infants, children, or adolescents, including neonatal, pediatric, and adolescent care.

(3) Methodology.—In establishing or updating Medicare reimbursement rates under this subsection, the Secretary may—

(A) apply Medicare payment methodologies under title XVIII of the Social Security Act;

(B) apply Medicaid or Children’s Health Insurance Program payment methodologies under title XIX or title XXI of such Act;

(C) use relative value, diagnosis-related group, or prospective payment principles consistent with Federal health care payment systems; and

(D) make such adjustments as are necessary to ensure access to care and the continued operation of essential providers.

(d) Single-price requirement.—

(1) In general.—Beginning January 1, 2027, a provider may not charge, and a payer may not pay, an amount in excess of the applicable ceiling price for any health care item or service. In determining whether such ceiling price has been exceeded, the total amount charged or paid, directly or indirectly, for a health care item or service shall be aggregated without regard to form, timing, recipient, or allocation.

(2) Balance billing prohibited.—A provider furnishing a health care item or service may not bill, charge, seek, collect, or receive from an individual, or from any other person on behalf of an individual, any amount in excess of the ceiling price, except for cost-sharing expressly permitted under Federal law.

(3) Contract terms void.—Any contract, agreement, or arrangement that purports to authorize payment or collection in excess of the ceiling price for a health care item or service shall be void as against public policy and unenforceable to the extent of such excess. The remainder of the contract shall remain enforceable.

(4) Preemption.—This section shall supersede any provision of State law, contract, or other agreement to the extent that such provision permits the charging or payment of an amount in excess of the applicable ceiling price, or otherwise frustrates the application of this section.

(5) Anti-evasion.—It shall be a violation of this subsection for a provider or payer, directly or indirectly, to evade or attempt to evade the requirements of this section.

(6) Rulemaking.—The Secretary may promulgate such regulations as are necessary to carry out this section.

(e) Enforcement and penalties.—

(1) Overpayment recovery.—Any amount paid in excess of the applicable ceiling price for a health care item or service shall be unlawful and treated as an overpayment. The Secretary may order restitution, refunds, and other appropriate monetary relief, including—

(A) reimbursement to a payer of any amount paid in excess of the ceiling price;

(B) refund to an individual, or to any other person who made payment on behalf of an individual, of any amount paid in excess of the ceiling price; and

(C) payment of interest on such excess amount, calculated from the date of payment at a rate determined by the Secretary.

(2) Civil monetary penalties.—The Secretary may impose civil monetary penalties on any provider or payer that violates subsection (d), including on a per-claim, per-bill, per-transaction, or per-day basis in the case of a continuing violation, and may impose enhanced penalties for repeated, reckless, or knowing violations.

(3) Equitable relief.—The Secretary may bring a civil action in an appropriate United States district court to obtain temporary, preliminary, or permanent injunctive relief, specific performance, rescission, reformation, disgorgement, restitution, or such other equitable relief as may be appropriate to enforce this section.

(4) FTC enforcement.—Any repeated, reckless, or knowing violation of subsection (d) shall constitute an unfair, deceptive, abusive act or practice in or affecting commerce under section 5(a) of the Federal Trade Commission Act (15 U.S.C. 45(a)). The Federal Trade

Commission shall enforce this paragraph in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this section.

(5) Audits and compliance authority.—The Secretary may conduct audits, inspect and copy records, require the submission of data, compel responses to interrogatories, require corrective action plans, and take such other actions as are necessary to monitor and secure compliance with this section.

(6) Complaints process.—The Secretary shall establish a process through which individuals, payers, employers, employees, contractors, and other persons may submit complaints, information, and documentary evidence regarding violations of this section. The Secretary may keep the identity of a complainant confidential to the extent practicable and consistent with law.

(7) Whistleblower and anti-retaliation protections.—A provider, payer, or other person may not discharge, demote, suspend, threaten, harass, deny payment to, refuse to contract with, discriminate against, or otherwise retaliate against any employee, contractor, agent, patient, enrollee, or other person because such person—

(A) provided information to the Secretary, the Federal Trade Commission, a State attorney general, or any other Federal or State agency concerning a possible violation of this section;

(B) testified, assisted, or participated in an investigation, audit, administrative proceeding, or judicial proceeding concerning a possible violation of this section; or

(C) refused to participate in conduct that such person reasonably believed would violate this section.

(8) Coordination with existing authorities.—The enforcement authorities provided under this subsection are in addition to, and do not limit, any other authority of the Secretary, the Inspector General of the Department of Health and Human Services, the Federal Trade Commission, the Attorney General, or a State attorney general under Federal or State law.

(f) Global budget carveout.—Beginning January 1, 2028, this section shall not apply to any health care item or service furnished by an institutional provider to the extent payment for such item or service is made under section 326(c) of the POPULIST Act.

(g) Rule of construction.—Nothing in this section shall be construed to amend, modify, or otherwise affect the operation of the Medicare program under title XVIII of the Social Security Act.

SEC. 303. PROVIDER PRICE TRANSPARENCY.

(a) Hospital price transparency.—

(1) Medicare.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end the following new section:

"SEC. 1899D. Hospital price transparency.

"(a) Definitions.—For purposes of this section:

"(1) Discounted cash price.—The term "discounted cash price" means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

"(2) Federal health care program.—The term "Federal health care program" has the meaning given such term in section 1128B.

"(3) Gross charge.—The term "gross charge" means the charge for an individual item or service that is reflected on a specified hospital's or provider of service's or supplier's, as applicable, chargemaster, absent any discounts.

"(4) Group health plan; group health insurance coverage; individual health insurance coverage.—The terms "group health plan", "group health insurance coverage", and "individual health insurance coverage" have the meaning given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

"(5) Payer-specific negotiated charge.—The term "payer-specific negotiated charge" means the charge that a specified hospital or provider of services or supplier, as applicable, has negotiated with a third party payer for an item or service.

"(6) Shoppable service.—The term "shoppable service" means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

"(7) Specified hospital.—The term "specified hospital" means a hospital, a critical access hospital, or a rural emergency hospital (as such terms are defined in section 1861).

"(8) Specified imaging service.—The term "specified imaging service" means an imaging service that is a Centers for Medicare & Medicaid Services-specified shoppable service (as described in subsection (b)(2)(A)(ii)(I)).

"(9) Third party payer.—The term "third party payer" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

"(b) Transparency requirement.—

"(1) In general.—Beginning July 1, 2027, each specified hospital that receives payment under this title for furnishing items and services shall comply with the price transparency requirement described in paragraph (2).

"(2) Requirement described.—

"(A) In general.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a specified hospital, that such hospital, in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge) for each year—

"(i) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

"(ii) information in a consumer-friendly format (as specified by the Secretary)—

"(I) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services;

"(II) that includes, with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished; and

"(iii) an attestation that all information made public pursuant to this subparagraph is complete and accurate.

"(B) Information described.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a specified hospital, the following:

"(i) A plain language description of each item or service, accompanied by, as applicable, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

"(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

"(iii) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for an item or service, the median cash price charged by the hospital to self-pay individuals for such item or service when provided in such settings for the previous 3 years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly

explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining charges for a self-pay individual).

"(iv) The payer-specific negotiated charges, as applicable, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting.

"(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

"(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

"In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

"(C) Uniform method and format.—Not later than July 1, 2027, the Secretary shall establish a standard, uniform method and format for specified hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to subparagraph (A)(ii). Such methods and formats—

"(i) shall, in the case of such method and format for making public standard charges pursuant to subparagraph (A)(i), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary);

"(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services as of the date of the enactment of this subparagraph;

"(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

"(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(3) Monitoring compliance.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each specified hospital's compliance with this subsection is reviewed not less frequently than once every 3 years.

"(4) Enforcement.—

"(A) In general.—In the case of a specified hospital that fails to comply with the requirements of this subsection—

"(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan to comply with such requirements); and

"(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

"(I) the Secretary shall, not later than 45 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

"(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

"(aa) submit to such hospital a request for a corrective action plan to comply with such requirements; or

"(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

"(B) Civil monetary penalty.—

"(i) In general.—Subject to clause (vii), in addition to any other enforcement actions or penalties that may apply under another provision of law, a specified hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 45 days after such request is made, and a specified hospital with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

"(I) in the case of a specified hospital with 30 or fewer beds, $300 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

"(II) in the case of a specified hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

"(III) in the case of a specified hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

"(IV) in the case of a specified hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

"(V) in the case of a specified hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $35 per bed per day).

"(ii) Increase authority.—In applying this subparagraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

"(I) the limitation on the per day amount of any penalty applicable to a specified hospital under clause (i)(I);

"(II) the limitations on the per bed per day amount of any penalty applicable under any of subclauses (II) through (V) of clause (i); and

"(III) the amounts specified in clause (iii)(II).

"(iii) Persistent noncompliance.—

"(I) In general.—In the case of a specified hospital (other than a specified hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection 2 or more times during a 1-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

"(II) Specified amount.—For purposes of subclause (I), the amount specified in this subclause is, with respect to a specified hospital—

"(aa) with more than 30 beds but fewer than 101 beds, an amount that is not less than $500,000 and not more than $1,000,000;

"(bb) with more than 100 beds but fewer than 301 beds, an amount that is greater than $1,000,000 and not more than $2,000,000;

"(cc) with more than 300 beds but fewer than 501 beds, an amount that is greater than $2,000,000 and not more than $4,000,000; and

"(dd) with more than 500 beds, an amount that is not less than $5,000,000 and not more than $10,000,000.

"(iv) Authority to waive or reduce penalty.—

"(I) In general.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a specified hospital located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

"(II) Limitation on application.—The Secretary may not elect to waive a penalty under subclause (I) with respect to a specified hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a specified hospital during a 6-year period.

"(v) Provision of technical assistance.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to specified hospitals requesting such assistance.

"(vi) Application of certain provisions.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(vii) Nonduplication of certain penalties.—The Secretary may not subject a specified hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this section for a period if the Secretary has imposed a civil monetary penalty on such hospital under section 2718(f) of the Public Health Service Act for failure to comply with the provisions of such section for such period.

"(C) Publication of hospital price transparency information.—Beginning on July 1, 2027, the Secretary shall make publicly available on the public website of the Centers for

Medicare & Medicaid Services information with respect to compliance with the requirements of this subsection and enforcement activities undertaken by the Secretary under this subsection. Such information shall be updated in real time and include—

"(i) the number of reviews of compliance with this subsection undertaken by the Secretary;

"(ii) the number of notifications described in subparagraph (A)(i) sent by the Secretary;

"(iii) the identity of each specified hospital that was sent such a notification and a description of the nature of such hospital's noncompliance with this subsection;

"(iv) the amount of any civil monetary penalty imposed on such hospital under subparagraph (B);

"(v) whether such hospital subsequently came into compliance with this subsection;

"(vi) any waivers or reductions of penalties made pursuant to a certification by the Secretary under subparagraph (B)(iv), including—

"(I) the name of any specified hospital that received such a waiver or reduction;

"(II) the dollar amount of each such penalty so waived or reduced; and

"(III) the rationale for the granting of each such waiver or reduction; and

"(vii) any other information as determined by the Secretary.

"(c) Imaging services price transparency.—

"(1) In general.—Beginning July 1, 2027, each provider of services and supplier that receives payment under this title for furnishing a specified imaging service, other than such a provider or supplier with respect to which standard charges and prices for such services furnished by such provider or supplier are made available by a hospital pursuant to section 1899D or section 2718(f) of the Public Health Service Act, shall—

"(A) make publicly available (in accordance with paragraph (3)) on an internet website the information described in paragraph (2) with respect to each such service that such provider of services or supplier furnishes; and

"(B) ensure that such information is updated not less frequently than annually.

"(2) Information described.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a provider of services or supplier and a specified imaging service, the following:

"(A) The discounted cash price for such service (or, if no such price exists, the gross charge for such service).

"(B) If required by the Secretary, the deidentified minimum payer-specific negotiated charge for such service and the deidentified maximum payer-specific negotiated charge for such service.

"(3) Uniform method and format.—Not later than January 1, 2027, the Secretary shall establish a standard, uniform method and format for providers of services and suppliers to use in making public information described in paragraph (2). Any such method and format—

"(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in section 1899D(b)(2)(C)(ii));

"(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

"(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(4) Monitoring compliance.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection.

"(5) Enforcement.—

"(A) In general.—In the case that the Secretary determines that a provider of services or supplier is not in compliance with paragraph (1)—

"(i) not later than 30 days after such determination, the Secretary shall notify such provider or supplier of such determination;

"(ii) upon request of the Secretary, such provider or supplier shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such paragraph; and

"(iii) if such provider or supplier continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent (or, in the case of such a provider or supplier that has submitted a corrective action plan described in clause (ii) in response to a request so described, after the date that is 90 days after such submission), the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first

determined that such provider or supplier was failing to comply with such paragraph) during which such failure to comply or failure to submit is ongoing.

"(B) Increase authority.—In applying this paragraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the amount of the civil monetary penalty under subparagraph (A)(iii).

"(C) Application of certain provisions.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(D) Authority to waive or reduce penalty.—

"(i) In general.—Subject to clause (ii), the Secretary may waive or reduce any penalty otherwise applicable with respect to a provider of services or supplier under this subparagraph if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such provider or supplier.

"(ii) Limitation.—The Secretary may not elect to waive or reduce a penalty under clause (i) with respect to a specific provider of services or supplier more than 3 times.

"(E) Provision of technical assistance.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to providers of services and suppliers requesting such assistance.

"(F) Clarification of nonapplicability of other enforcement provisions.—Notwithstanding any other provision of this title, this paragraph shall be the sole means of enforcing the provisions of this subsection.

"(d) Ensuring accessibility through implementation.—In implementing the amendments made by this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.".

(2) PHSA.—Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18) is amended by adding at the end the following new subsection:

"(f) Hospital transparency requirement.—

"(1) In general.—Beginning July 1, 2027, each hospital shall comply with the price transparency requirement described in paragraph (2).

"(2) Requirement described.—

"(A) In general.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a hospital, that such hospital, in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge) for each year—

"(i) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

"(ii) information in a consumer-friendly format (as specified by the Secretary)—

"(I) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

"(II) that includes, with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished; and

"(iii) an attestation that all information made public pursuant to this subparagraph is complete and accurate.

"(B) Information described.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a hospital, the following:

"(i) A plain language description of each item or service, accompanied by, as applicable, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, current procedure terminology codes, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

"(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

"(iii) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for an item or service, the median cash price charged by the hospital to self-pay individuals for such item or service when provided in such settings for the previous 3

years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining charges for a self-pay individual).

"(iv) The payer-specific negotiated charges, as applicable, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting.

"(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

"(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

"In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

"(C) Uniform method and format.—Not later than July 1, 2027, the Secretary shall establish a standard, uniform method and format for hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to subparagraph (A)(ii). Such methods and formats—

"(i) shall, in the case of such method and format for making public standard charges pursuant to subparagraph (A)(i), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary);

"(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services as of the date of the enactment of this subparagraph;

"(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

"(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(3) Monitoring compliance.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such

process shall ensure that each hospital's compliance with this subsection is reviewed not less frequently than once every 3 years.

"(4) Enforcement.—

"(A) In general.—In the case of a hospital that fails to comply with the requirements of this subsection—

"(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan to comply with such requirements); and

"(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

"(I) the Secretary shall, not later than 45 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

"(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

"(aa) submit to such hospital a request for a corrective action plan to comply with such requirements; or

"(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

"(B) Civil monetary penalty.—

"(i) In general.—In addition to any other enforcement actions or penalties that may apply under another provision of law, a hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 45 days after such request is made, and a hospital with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

"(I) in the case of a hospital with 30 or fewer beds, $300 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

"(II) in the case of a hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

"(III) in the case of a hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

"(IV) in the case of a hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

"(V) in the case of a hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $35 per bed per day).

"(ii) Increase authority.—In applying this subparagraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

"(I) the limitation on the per day amount of any penalty applicable to a hospital under clause (i)(I);

"(II) the limitations on the per bed per day amount of any penalty applicable under any of subclauses (II) through (V) of clause (i); and

"(III) the amounts specified in clause (iii)(II).

"(iii) Persistent noncompliance.—

"(I) In general.—In the case of a hospital (other than a hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection 2 or more times during a 1-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

"(II) Specified amount.—For purposes of subclause (I), the amount specified in this subclause is, with respect to a hospital—

"(aa) with more than 30 beds but fewer than 101 beds, an amount that is not less than $500,000 and not more than $1,000,000;

"(bb) with more than 100 beds but fewer than 301 beds, an amount that is greater than $1,000,000 and not more than $2,000,000;

"(cc) with more than 300 beds but fewer than 501 beds, an amount that is greater than $2,000,000 and not more than $4,000,000; and

"(dd) with more than 500 beds, an amount that is not less than $5,000,000 and not more than $10,000,000.

"(iv) Authority to waive or reduce penalty.—

"(I) In general.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a hospital located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

"(II) Limitation on application.—The Secretary may not elect to waive a penalty under subclause (I) with respect to a hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a hospital during a 6-year period.

"(v) Provision of technical assistance.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this section to hospitals requesting such assistance.

"(vi) Application of certain provisions.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(vii) Nonduplication of penalties.—The Secretary may not subject a hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this subsection for a period if the Secretary has imposed a civil monetary penalty on such hospital under section 1899D of the Social Security Act for failure to comply with the provisions of such section for such period.

"(C) Publication of hospital price transparency information.—Beginning on July 1, 2027, the Secretary shall make publicly available on the public website of the Centers for Medicare & Medicaid Services information with respect to compliance with the requirements of this subsection and enforcement activities undertaken by the Secretary under this subsection. Such information shall be updated in real time and include—

"(i) the number of reviews of compliance with this subsection undertaken by the Secretary;

"(ii) the number of notifications described in subparagraph (A)(i) sent by the Secretary;

"(iii) the identity of each hospital that was sent such a notification and a description of the nature of such hospital's noncompliance with this subsection;

"(iv) the amount of any civil monetary penalty imposed on such hospital under subparagraph (B);

"(v) whether such hospital subsequently came into compliance with this subsection;

"(vi) any waivers or reductions of penalties made pursuant to a certification by the Secretary under subparagraph (B)(iv), including—

"(I) the name of any hospital that received such a waiver or reduction;

"(II) the dollar amount of each such penalty so waived or reduced; and

"(III) the rationale for the granting of each such waiver or reduction; and

"(vii) any other information as determined by the Secretary.

"(5) Ensuring accessibility through implementation.—In implementing the amendments made by this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.

"(6) Definitions.—For purposes of this subsection:

"(A) Discounted cash price.—The term "discounted cash price" means the charge that applies to an individual who pays cash, or cash equivalent, for a hospital-furnished item or service.

"(B) Federal health care program.—The term "Federal health care program" has the meaning given such term in section 1128B of the Social Security Act.

"(C) Gross charge.—The term "gross charge" means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

"(D) Payer-specific negotiated charge.—The term "payer-specific negotiated charge" means the charge that a hospital has negotiated with a third party payer for an item or service.

"(E) Shoppable service.—The term "shoppable service" means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

"(F) Third party payer.—The term "third party payer" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.".

(3) Conforming amendments.—

(A) PHSA.—Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18) is amended—

(i) in subsection (b)(3), by inserting “(other than the provisions of subsection (f))” after “this section”; and

(ii) in subsection (e), by adding at the end the following new sentence: “The preceding provisions of this subsection shall not apply beginning on July 1, 2027.”.

(B) Clerical amendment.—The table of contents in part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end the following new section:

“Sec. 1395nnn. Hospital price transparency.”.

(4) Accessibility through implementation.—In implementing the amendments made by this subsection, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital’s provision of interpretation services or the hospital’s provision of translations of charges and information.

(b) Clinical diagnostic laboratory test price transparency.—Section 1846 of the Social Security Act (42 U.S.C. 1395w–2) is amended—

(1) in the header, by inserting “and additional requirements” after “sanctions”; and

(2) by adding at the end the following new subsection:

"(c) Price transparency requirement.—

"(1) In general.—Beginning July 1, 2027, any applicable laboratory that receives payment under this title for furnishing any specified clinical diagnostic laboratory test under this title shall—

"(A) make publicly available on an internet website the information described in paragraph (2) with respect to each such specified clinical diagnostic laboratory test that such laboratory so furnishes; and

"(B) ensure that such information is updated not less frequently than annually.

"(2) Information described.—For purposes of paragraph (1), the information described in this paragraph is, with respect to an applicable laboratory and a specified clinical diagnostic laboratory test, the following:

"(A) The discounted cash price for such test (or, if no such price exists, the gross charge for such test).

"(B) The deidentified minimum payer-specific negotiated charge between such laboratory and any third party payer for such test.

"(C) The deidentified maximum payer-specific negotiated charge between such laboratory and any third party payer for such test.

"(3) Uniform method and format.—Not later than July 1, 2027, the Secretary shall establish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format—

"(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in section 1899D(b)(2)(C)(ii));

"(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

"(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(4) Inclusion of ancillary services.—Any price or rate for a specified clinical diagnostic laboratory test available to be furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the price or rate (as applicable) for any ancillary item or service (such as specimen collection services) that would normally be furnished by such laboratory as part of such test, as specified by the Secretary.

"(5) Enforcement.—

"(A) In general.—In the case that the Secretary determines that an applicable laboratory is not in compliance with paragraph (1)—

"(i) not later than 30 days after such determination, the Secretary shall notify such laboratory of such determination; and

"(ii) if such laboratory continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent, the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such laboratory was failing to comply with such paragraph) during which such failure is ongoing.

"(B) Increase authority.—In applying this paragraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (A)(ii).

"(C) Application of certain provisions.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(6) Provision of technical assistance.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to applicable laboratories requesting such assistance.

"(7) Definitions.—In this subsection:

"(A) Applicable laboratory.—The term "applicable laboratory" has the meaning given such term in section 414.502 of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by a hospital pursuant to section 1899D or section 2718(f) of the Public Health Service Act (42 U.S.C. 300gg-18).

"(B) Discounted cash price.—The term "discounted cash price" means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

"(C) Gross charge.—The term "gross charge" means the charge for an individual item or service that is reflected on an applicable laboratory's chargemaster, absent any discounts.

"(D) Payer-specific negotiated charge.—The term "payer-specific negotiated charge" means the charge that an applicable laboratory has negotiated with a third party payer for an item or service.

"(E) Specified clinical diagnostic laboratory test.—The term "specified clinical diagnostic laboratory test" means a clinical diagnostic laboratory test that is included on the list of shoppable services specified by the Centers for Medicare & Medicaid Services (as described in section 1899D(b)(2)(A)(ii)(I)), other than such a test that is only available to be furnished by a single provider of services or supplier.

"(F) Third party payer.—The term "third party payer" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.".

(c) Ambulatory surgical center price transparency.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(aa) Ambulatory surgical center price transparency.—

"(1) In general.—Beginning July 1, 2027, each ambulatory surgical center that receives payment under this title for furnishing items and services shall comply with the price transparency requirement described in paragraph (2).

"(2) Requirement described.—

"(A) In general.—For purposes of paragraph (1), the price transparency requirement described in this subsection is, with respect to an ambulatory surgical center, that such surgical center in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge), for each year—

"(i) all of the ambulatory surgical center's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such surgical center;

"(ii) information on the ambulatory surgical center's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by such surgical center, and as many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

"(iii) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the ambulatory surgical center, an indication that such service is not so furnished.

"(B) Information described.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices (as applicable) made public by an ambulatory surgical center, the following:

"(i) A plain language description of each item or service, accompanied by, as applicable, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

"(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service.

"(iii) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the median cash price charged to self-pay individuals for such item or service for the previous 3 years, expressed as a dollar amount).

"(iv) The current payer-specific negotiated charges, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that applies to each such item or service.

"(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

"(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

"(C) Uniform method and format.—Not later than July 1, 2027, the Secretary shall establish a standard, uniform method and format for ambulatory surgical centers to use in making public standard charges and a standard, uniform method and format for such centers to use in making public prices pursuant to subparagraph (A). Any such method and format—

"(i) shall, in the case of such charges made public by an ambulatory surgical center, ensure that such charges are made available in a machine-readable format (or successor technology);

"(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services as of the date of the enactment of this paragraph;

"(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

"(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(3) Monitoring compliance.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each ambulatory surgical center's compliance with this subsection is reviewed not less frequently than once every 3 years.

"(4) Enforcement.—

"(A) In general.—In the case of an ambulatory surgical center that fails to comply with the requirements of this subsection—

"(i) the Secretary shall notify such ambulatory surgical center of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

"(ii) upon request of the Secretary, the ambulatory surgical center shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such requirements.

"(B) Civil monetary penalty.—

"(i) In general.—In addition to any other enforcement actions or penalties that may apply under another provision of law, an ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of an ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each subsequent day during which such failure is ongoing (not to exceed $300 per day).

"(ii) Increase authority.—In applying this subparagraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to an ambulatory surgical center under clause (i).

"(iii) Application of certain provisions.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(iv) Authority to waive or reduce penalty.—

"(I) In general.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to an ambulatory surgical center located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such surgical center.

"(II) Limitation on application.—The Secretary may not elect to waive a penalty under subclause (I) with respect to an ambulatory surgical center more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a surgical center more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to an ambulatory surgical center during a 6-year period.

"(5) Definitions.—For purposes of this section:

"(A) Discounted cash price.—The term "discounted cash price" means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service furnished by an ambulatory surgical center.

"(B) Federal health care program.—The term "Federal health care program" has the meaning given such term in section 1128B.

"(C) Gross charge.—The term "gross charge" means the charge for an individual item or service that is reflected on an ambulatory surgical center's chargemaster, absent any discounts.

"(D) Group health plan; group health insurance coverage; individual health insurance coverage.—The terms "group health plan", "group health insurance coverage", and "individual health insurance coverage" have the meaning given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

"(E) Payer-specific negotiated charge.—The term "payer-specific negotiated charge" means the charge that an ambulatory surgical center has negotiated with a third party payer for an item or service.

"(F) Shoppable service.—The term "shoppable service" means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

"(G) Third party payer.—The term "third party payer" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.".

SEC. 304. REPEALING ELIGIBILITY RESTRICTION ON PREMIUM SUBSIDIES.

Section 5000A(f)(1)(B) of title 26, United States Code, disallowing refundable credits for health insurance through the Health Insurance Exchange under chapter 36B of title 26, when a minimally qualified employer-sponsored plan is available, is repealed.

SEC. 305. REPEALING LARGE EMPLOYERS' HEALTH INSURANCE MANDATE.

Section 4980H of title 26, United States Code, penalizing applicable large employers who fail to offer minimum essential coverage, is repealed.

SEC. 306. CODIFYING PROHIBITION OF MEDICAL DEBT REPORTING.

(a) In general.—

(1) Incorporation of specified regulations.—The provisions of the final rule promulgated by the Consumer Financial Protection Bureau, entitled "Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V)", as published in the Federal Register on January 14, 2025 (90 Fed. Reg. 3276), are

incorporated into this Act and shall be treated as though such provisions are set forth in this subsection.

(2) Effect of incorporation.—The regulations incorporated under subsection (a) may be altered only by means of an Act of Congress. To the extent that any provision of such regulations does not conform with this Act, the provisions of this Act shall govern.

(3) Definition of regulation.—In this section, the term "regulation" means any rule, regulation, guideline, interpretation, order, or requirement of general applicability prescribed by any officer or employee of the executive branch.

(b) Rulemaking authority.—

(1) In general.—The Consumer Financial Protection Bureau is expressly authorized to prescribe rules of general applicability governing the furnishing of information to consumer reporting agencies under the Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) as transferred and vested in the Bureau under Title X of the Dodd-Frank Wall Street Reform and Consumer Protection Act (12 U.S.C. 5481 et seq.).

(2) Minimum floor.—Rules prescribed under paragraph (1) may impose requirements that are more stringent than the requirements incorporated under subsection (a), but may not prescribe requirements that are less stringent than such incorporated requirements, except as expressly provided by an Act of Congress.

(c) States not preempted.—Nothing in this section shall be construed to preempt, displace, or limit any law of a State that provides equal or greater protection with respect to the reporting, furnishing, or use of medical debt or medical debt information. A State law shall not be considered inconsistent with Federal law solely because it prohibits or further restricts the reporting, furnishing, or use of medical debt or medical debt information.

Subtitle A—Addressing Concentration in Health Care

SEC. 311. PROHIBITIONS RELATING TO ANTICOMPETITIVE OWNERSHIP AND CONTRACTS.

(a) Definitions.—In this section:

(1) Antitrust Division.—The term “Antitrust Division” means the Antitrust Division of the Department of Justice, acting through the Assistant Attorney General in charge of the Antitrust Division.

(2) Commission.—The term "Commission" means the Federal Trade Commission.

(3) Drug; device.—The terms “drug” and “device” have the meanings given those terms, respectively, in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321).

(4) Health care administrative services entity.—The term “health care administrative services entity” means any person that, for compensation and in the ordinary course of

business, provides to 1 or more unaffiliated persons any of the following services with respect to health care items or services or health insurance benefits:

(A) Claims clearinghouse services, including electronic routing, formatting, or transmission of health care claims or related eligibility or remittance transactions.

(B) Prior authorization or utilization management platform services, including operation of a platform that receives, processes, adjudicates, or transmits prior authorization requests or determinations.

(C) Claims payment integrity, coding, billing, revenue-cycle, audit, or risk adjustment platform services, including operation of a platform used to make or influence coverage or payment determinations.

(D) Other gatekeeper administrative platform services specified by the Commission by rule that function as a bottleneck for payment, coverage, or access.

(5) "Health care vertical".—The term "health care vertical" means the following:

(A) A provider or a management services organization.

(B) A health insurance issuer.

(C) A pharmacy benefit manager.

(D) A pharmacy.

(E) A health care administrative services entity.

(F) A prescription drug or medical device wholesaler.

(6) Health insurance issuer.—The term “health insurance issuer” has the meaning given that term in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(7) Health plan.—The term “health plan” means any public or private plan or arrangement that provides or pays for health care benefits, including prescription drug benefits.

(8) Health plan sponsor.—The term “health plan sponsor” means any person or entity that establishes, maintains, administers, or funds a health plan.

(9) Management services organization.—The term “management services organization” means an entity that has entered into an agreement with a provider to furnish services to such provider, including services relating to payroll, human resources, employment screening, payer contracting, billing and collection, coding, information technology services, patient scheduling, property or equipment leasing, and administrative or business services that do not constitute the practice of medicine.

(10) Person.—The term “person” has the meaning given the term in section 8 of the Sherman Act (15 U.S.C. 7).

(11) Pharmacy.—The term “pharmacy” has the meaning given the term "dispenser" in section 360eee of title 21, United States Code.

(12) Pharmacy benefit manager.—The term “pharmacy benefit manager” means any person, business, or other entity, such as a third-party administrator, regardless of whether such person, business, or other entity identifies itself as a pharmacy benefit manager, that, either directly or indirectly through an intermediary (including an affiliate, subsidiary, or agent) or an arrangement with a third party—

(A) acts as a negotiator of prices, rebates, fees, or discounts for prescription drugs on behalf of a health plan or health plan sponsor;

(B) contracts with pharmacies to create pharmacy networks and designs and manages such networks; or

(C) manages or administers the prescription drug benefits provided by a health plan, including the processing and payment of claims for prescription drugs, arranging alternative access to or funding for prescription drugs, the performance of utilization management services, including drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, or the provision of related services.

(13) Prescription drug.—The term “prescription drug” means a drug approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is subject to section 503(b)(1) of such Act (21 U.S.C. 353(b)(1)).

(14) Prescription drug or medical device wholesaler.—The term “prescription drug or medical device wholesaler”—

(A) means a person engaged in wholesale distribution of a prescription drug or a device; and

(B) includes a parent (direct or indirect) of, a subsidiary (direct or indirect, and partial or complete) of, and any entity under the common control or ownership of a person described in subparagraph (A).

(15) Profits.—The term “profits” means, with respect to any person and any month, the amount equal to the greater of—

(A) the net income (or loss) of such person before provision for income taxes for such month, as determined in accordance with generally accepted accounting principles and consistent with the accounting principles used in the most recent audited consolidated financial statements of such person; and

(B) 4 percent of the gross revenues of such person for such month, as so determined.

(16) Provider.—The term “provider” means a practitioner or entity the National Provider Identifier registration of which has 1 or more taxonomy codes under the National Uniform Claim Committee (or any successor organization), including any physician practice, ambulatory surgery center, urgent care center, post-acute care facility, home-health provider, or hospital, but such term does not include a pharmacy or a management services organization, as defined in this section.

(17) Unaffiliated.—The term “unaffiliated”, with respect to a person providing a service, means not under common ownership or control (directly or indirectly) with the person receiving such service.

(18) Wholesale distribution.—The term “wholesale distribution”—

(A) means the sale, purchase, trade, delivery, handling, storage, or receipt of a drug or device by a person other than the consumer or patient; and

(B) does not include—

(i) dispensing of a drug or device to a consumer or patient by a person having a valid license under State law to do so;

(ii) purchase, handling, storage, receipt, or other acquisition of a drug or device by—

(I) a person having a valid license under State law to dispense or administer drugs or devices; or

(II) a hospital, pharmacy, or other health care entity, for use by such person, hospital, pharmacy, or other health care entity;

(iii) sale, purchase, trade, delivery, handling, storage, or receipt of a drug or device by a person holding an application approved under section 505 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) for such drug or device, a co-licensed partner of any person described in this clause, or an affiliate of any person described in this clause;

(iv) possession by, receipt by, or transfer to, a—

(I) third-party logistics provider that provides or coordinates warehousing, or other logistics services in interstate commerce; or

(II) repackager who owns or operates an establishment that repacks and relabels drugs or devices for further sale or distribution, provided that such

third-party logistics provider or repackager does not take ownership of the drug or device;

(v) possession by, receipt by, or transfer to, a common carrier that transports a drug or device, provided that the common carrier does not take ownership of the drug or device;

(vi) intracompany transfer of any drug or device by an entity described in clause (i), (ii), or (iii), including transfers between affiliates thereof, or warehousing by such person incidental to such intracompany transfer; or

(vii) returns or reverse distribution by any person described in clause (i), (ii), (iii), (iv), or (v).

(b) Prohibition on ownership of more than 1 health care vertical.—

(1) (A) In general.—It shall be unlawful for any person to directly or indirectly own, operate, control, or direct the operation of any entity or combination of entities engaged in more than 1 health care vertical, in or affecting interstate or foreign commerce.

(B) Prohibition on new acquisitions.—After July 4, 2026, no person may acquire, directly or indirectly, control of assets or operations in a health care vertical other than the health care vertical in which such person already engages, in violation of paragraph (1).

(2) Rulemaking.—Not later than September 30, 2026, the Commission and the Antitrust Division shall, by joint rule, define for purposes of this section—

(A) a de minimis threshold of revenue or market share of a health care vertical in a geographic market below which shall be excluded from prohibition under this subsection; and

(B) the requirements that place a person under common control or in affiliation with an entity subject to the prohibition under paragraph (1), including contractual arrangements of operational control;

(C) milestones for divestment to insure compliance within the deadline under subsection (c), provided such milestones may not be later than permitted under subsection (d), including but not limited to—

(i) filing of a divestment plan;

(ii) the length of time the Commission and Antitrust Division will review such plan;

(iii) filing of a revised plan, if necessary;

(iv) notification of the person acquiring such divestment;

(v) the submission of any transaction filing required by section 7A of the Clayton Act (15 U.S.C. 18a) by the person acquiring such divestment; and

(vi) the completion of such divestment; and

(D) for each milestone, which, for a person's knowing and willful failure to meet, whether the Commission and the Antitrust Division shall seek—

(i) penalties under subsection (e)(3);

(ii) appointment of a divestment trustee for such person under subsection (e)(4); or

(iii) both clauses (i) and (ii).

(c) Divestment.—Not later than July 1, 2028, any person in violation of subsection (b) shall divest such interests as are necessary to come into compliance.

(d) FTC and DOJ review.—

(1) Divestiture plan required.—Not later than April 1, 2027, any person required to divest under subsection (c) shall submit to the Commission and the Antitrust Division a divestiture plan. Such plan—

(A) shall be submitted to the Commission and the Antitrust Division in the same manner, and containing substantially similar information, as a transaction filing under section 7A of the Clayton Act (15 U.S.C. 18a), without respect to any threshold, exemption, or other limitation of such section; and

(B) shall include—

(i) identification of the business, assets, or interests to be divested to come into compliance with subsection (b);

(ii) identification of the proposed acquiring person, if known;

(iii) a timetable for execution;

(iv) any transitional services proposed; and

(v) such other information as the Commission may require by rule.

(2) Agency review process.—Not later than 180 days after receipt of a divestiture plan under paragraph (1), but in no case later than October 1, 2027, the Commission and the Antitrust Division shall review the plan.

(A) The Commission and the Antitrust Division may designate 1 agency to take the lead in conducting the review and communicating with the person submitting the plan.

(B) The lead agency shall review the effect on competition, financial viability, and the public interest—

(i) of the divestiture; and

(ii) of the subsequent acquisition of the divested entity by the acquiring person.

(C) Any request for additional information by an agency shall be made within 30 days of receipt of the plan.

(D) (i) A divestiture plan that identifies a proposed acquiring person may be approved only if the lead agency determines that—

(I) the proposed acquisition of the divested business, assets, or interests by such acquiring person is consistent with subsection (b);

(II) the proposed acquisition would not materially harm competition or otherwise undermine the purposes of this section; and

(III) any statutory reporting, waiting period, or approval requirement applicable to the proposed acquisition will be satisfied before consummation.

(ii) A divestiture plan may be submitted and reviewed without identifying a proposed acquiring person, but no sale, transfer, assignment, or other disposition to an acquiring person shall be consummated if either the Commission or the Antitrust Division disapprove in writing.

(E) Not later than the end of the review period, the lead agency shall notify the person in writing—

(i) whether the plan is approved, approved with conditions, or disapproved; and

(ii) the reasons for any disapproval or conditions.

(F) Approval standard.—A divestiture plan shall be treated as approved only if, before the end of the review period, the lead agency has approved the plan in writing, whether unconditionally or subject to conditions accepted in writing by the person submitting the plan, and neither the Commission nor the Antitrust Division has disapproved the plan in writing.

(3) Revised plan following disapproval.—If a plan is disapproved under paragraph (2), the person shall submit a revised divestiture plan not later than 60 days after receipt of the disapproval notice.

(A) Not later than 180 days after receipt of a revised plan, but in no case later than May 1, 2028, the lead agency shall review the revised plan under the procedures set forth in paragraph (2).

(4) No tolling.—No submission, resubmission, agency review, negotiation, request for additional information, waiting period, court proceeding, or other matter shall toll or extend any deadline under this section.

(5) Consequences of noncompliance.—A person required to divest under subsection (c) shall be subject to subsection (e)(3), subsection (e)(4), or both, if such person fails to:

(A) submit a divestiture plan under paragraph (1);

(B) submit a revised plan under paragraph (3) if required to do so;

(C) obtain approval of either—

(i) a plan under paragraph (2); or

(ii) a revised plan under paragraph (3);

(D) conform to agreed upon conditions of an approved plan; or

(E) conclude the divestment required by subsection (c).

(6) Blocking of actions.—

(A) The Commission and the Antitrust Division, jointly or separately, may bring a civil action in any court of competent jurisdiction to block any action that would harm competition to the detriment of the public interest.

(e) Enforcement.—

(1) In general.—When the Inspector General of the Department of Health and Human Services, the Commission, the Antitrust Division, or an attorney general of a State has reason to believe that a person is in violation of subsection (b) or (c), such Inspector General, Commission, Antitrust Division, or attorney general of a State may bring a civil action in an appropriate district court of the United States.

(2) Injunctive and equitable relief.—In any action described in paragraph (1), the applicable court, on a finding that a person is in violation of subsection (b) or (c), shall issue an order requiring such person—

(A) to cease and desist from such violation, and, if applicable, divest such interests as are necessary to come into compliance with subsection (b) and subsection (c); and

(B) to disgorge any revenue received from an entity subject to divestment for the period of such violation.

(3) Penalties.—

(A) In general.—For any person that does not comply with the milestones specified under subsection (b)(2), the lead agency shall cause 10 percent of the profits of the person to be transferred into escrow on a monthly basis, to be—

(i) returned to the person if divestment occurs by the deadline under subsection (c); or

(ii) deposited into the fund described in subsection (e)(5) if divestment does not occur by the deadline under subsection (c).

(B) Escrow administration and certification.—Any transfer into escrow under subparagraph (A) shall be deposited with the Secretary of the Treasury into a segregated account established for purposes of this section.

(i) Not later than 15 days after the end of each month for which a transfer is required, the person shall submit to the Chair of the Commission and the Antitrust Division a certification, signed by the chief executive officer and chief financial officer, attesting to the calculation of profits and gross revenues for such month and the amount transferred.

(ii) Not later than 120 days after the end of each fiscal year, the person shall submit a reconciliation based on audited financial statements, and shall pay any underpayment plus interest, or shall receive a return of any overpayment, as applicable.

(C) Judicial review.—A person subject to a transfer requirement under subparagraph (A) may, not later than 30 days after notice of such requirement, petition for review in the United States Court of Appeals for the District of Columbia Circuit. The filing of a petition for review shall not stay any obligation to transfer amounts into escrow unless the court orders otherwise.

(4) Trustee.—The Commission or the Antitrust Division may apply to a court of competent jurisdiction for the appointment of a divestiture trustee.

(A) The divestiture trustee shall have the authority, at the expense of the person required to divest, to take such actions as are necessary to effectuate the divestiture required under this section, including selling, transferring, assigning, or otherwise disposing of the business, assets, entity, or interests required to be divested.

(B) The person required to divest shall cooperate fully with the divestiture trustee and shall take no action to interfere with, delay, or impede the divestiture.

(C) Any proposed sale by the divestiture trustee shall be subject to approval under subsection (d).

(D) Duty of trustee.—The divestiture trustee shall act in the interest of effectuating prompt compliance with this section and restoring competition, and shall not be required to maximize the value received by the person required to divest.

(5) Deposit.—Any revenue disgorged pursuant to an action under paragraph (1) shall be deposited into the Medicare for All Trust Fund established by section 327 of this title.

(6) Other relief.—In addition to any relief obtained under paragraph (1) or (2), the court may grant any other equitable relief necessary to redress and prevent recurrence of the violation.

(f) Anti-circumvention.—It shall be unlawful for any person to evade or attempt to evade this section, including by entering into an agreement or contract, engaging in a transaction, structuring an entity, or recreating, through contractual means, the conflicts of interest described in subsection (b).

(g) Rulemaking authority.—The Commission and the Antitrust Division shall, by joint rule, promulgate regulations to carry out this section.

(h) Reports required.—The Chair of the Commission and the Antitrust Division shall submit to the appropriate congressional committees quarterly reports on compliance with this section, including the status of any divestitures required under this section.

(i) Rule of construction.—Nothing in this section shall be construed to limit the authority of the Commission, the Inspector General of the Department of Health and Human Services, the Department of Justice, or the attorney general of a State under any other provision of law.

SEC. 312. FTC AUTHORITY TO ADDRESS UNFAIR HOSPITAL COMPETITION.

(a) Section 4 of the Federal Trade Commission Act (15 U.S.C. 44) is amended—

(1) by striking "'Commerce'" and inserting "(a) 'Commerce'";

(2) by striking "'Corporation'" and inserting "(b) 'Corporation'";

(3) by striking "'Documentary evidence'" and inserting "(c) 'Documentary evidence'";

(4) by striking "'Acts to regulate commerce'" through the period, and inserting

"(d) 'Acts to regulate commerce' means subtitle IV of title 49, United States Code, the Communications Act of 1934 (47 U.S.C. 151 et seq.) and all acts amendatory thereof and supplementary thereto, and includes with respect to unfair methods of competition, any hospital organization or cooperative hospital service organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code."

(5) by striking "'Antitrust Acts' " and inserting "(d) 'Antitrust Acts'";

(6) by striking "'Banks'", inserting "(e) 'Banks'", and moving subsection (e), so designated, two ems to the left; and

(7) by striking "'Foreign law enforcement agency'", inserting "(f) 'Foreign law enforcement agency'", and moving subsection (f), so designated, one em to the left.

Subtitle B—Medicare for All

SEC. 321. ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM

(a) Establishment of the program.—There is hereby established a national health insurance program, referred to in this Act as the Medicare for All Program, to provide comprehensive protection against the costs of health care and health-related items and services, in accordance with the standards specified in, or established under, this subtitle.

(b) Universal entitlement to benefits.—

(1) In general.—Every individual who is a resident of the United States is entitled to benefits for health care items and services under this subtitle. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this subtitle.

(2) Treatment of other individuals.—The Secretary—

(A) may make eligible for benefits for health care items and services under this subtitle other individuals not described in paragraph (1) and regulate their eligibility to ensure that every person in the United States has access to health care; and

(B) shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care items and services provided under this subtitle.

(c) Freedom of choice.—Any individual entitled to benefits under this subtitle may obtain health care items and services from any institution, agency, or individual qualified to participate under this subtitle.

(d) Non-discrimination.—

(1) In general.—No person shall, on the basis of race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in or be denied the benefits of the program established under this subtitle (except as expressly authorized by this subtitle for purposes of enforcing eligibility standards described in subsection (b)), or be subject to any reduction of benefits or other discrimination by any participating provider (as described in section 323(a)(1)), or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this subtitle.

(2) Claims of discrimination.—

(A) Administrative procedure.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of paragraph (1).

(B) Jurisdiction.—Any person aggrieved by a violation of paragraph (1) may file suit in any district court of the United States having jurisdiction of the parties. A person may bring an action under this subparagraph concurrently with such administrative remedies as established under subparagraph (A).

(C) Damages.—If the court finds a violation of paragraph (1), the court may grant compensatory and punitive damages (including damages for emotional harm), declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.

(3) Continued application of laws.—Nothing in this title shall be construed to invalidate or otherwise limit any of the rights, remedies, procedures, or legal standards available to individuals aggrieved under other Federal laws, including section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), title II of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131 et seq.), or the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.). Nothing in this title shall be construed to supersede State laws that provide additional protections against discrimination on any basis described in paragraph (1).

(e) Enrollment.—

(1) In general.—The Secretary shall provide a mechanism for the enrollment of individuals eligible for benefits under the Medicare for All Program. Such mechanism shall—

(A) include a process for the automatic enrollment of individuals at the time of birth in the United States, or upon establishment of residency in the United States;

(B) provide for the enrollment, as of the applicable date described in subsection (f), of all individuals who are eligible to be enrolled as of such date; and

(C) include a process for the enrollment of individuals made eligible for health care items and services under subsection (b)(2).

(2) Issuance of Medicare for All cards.—In conjunction with an individual's enrollment for benefits under this subtitle, the Secretary shall provide for the issuance of a Medicare for All card that shall be used for purposes of identification and processing of claims for benefits under the Medicare for All Program. Such card shall not include an individual's Social Security number.

(f) Effective date of benefits.—

(1) In general.—Except as provided in paragraph (2), benefits shall first be available under the Medicare for All Program for items and services furnished on January 1, 2029.

(2) Immediate coverage of children.—

(A) In general.—For any eligible individual under subsection (b) who has not yet attained the age of 19 as of July 4, 2027, benefits shall first be available under the Medicare for All Program for items and services furnished on January 1, 2027.

(B) Option to continue in other coverage during transition period.—Any person eligible to receive benefits under subparagraph (A) may elect to maintain coverage described in section 328, private health insurance coverage, or coverage offered pursuant to subsection 329 (including the amendments made by such section) until January 1, 2029.

(g) Prohibition against duplicating coverage.—

(1) In general.—Beginning on January 1, 2029, it shall be unlawful for—

(A) a private health insurer to sell health insurance coverage that duplicates the benefits provided under the Medicare for All Program; or

(B) an employer to provide benefits for an employee, former employee, or the dependents of such employee or former employee that duplicate the benefits provided under the Medicare for All Program.

(2) Construction.—Nothing in this subtitle shall be construed to prohibit the sale of health insurance coverage for additional benefits not covered by the Medicare for All Program, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

SEC. 322. COMPREHENSIVE BENEFITS; COST-SHARING; EXCLUSIONS AND LIMITATIONS; MEDICAID LONG-TERM CARE CONTINUATION; STATE STANDARDS.

(a) Comprehensive benefits.—Subject to the other provisions of this subtitle, individuals enrolled for benefits under the Medicare for All Program are entitled to have payment made by the Secretary to a participating provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) Hospital services.—Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.

(2) Ambulatory patient services.—Ambulatory patient services.

(3) Primary and preventive services.—Primary and preventive services, including chronic disease management.

(4) Prescription drugs and medical devices.—Prescription drugs and medical devices, including outpatient prescription drugs, biological products, medical devices, and all contraceptive items approved by the Food and Drug Administration.

(5) Mental health and substance use treatment services.—Mental health and substance use treatment services, including inpatient care and treatment for co-occurring mental illness and substance use disorders.

(6) Laboratory and diagnostic services.—Laboratory and diagnostic services.

(7) Comprehensive reproductive care.—Comprehensive reproductive care, including abortion, contraception, and assistive reproductive technology.

(8) Comprehensive maternity and newborn care.—Comprehensive maternity and newborn care.

(9) Comprehensive gender-affirming health care.—Comprehensive gender-affirming health care.

(10) Oral health, audiology, and vision services.—Oral health, audiology, and vision services.

(11) Rehabilitative and habilitative services.—Rehabilitative and habilitative services, including devices.

(12) Emergency services.—Emergency services, including transportation.

(13) Pediatrics.—Pediatrics, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))).

(14) Necessary transportation.—Necessary transportation to receive health care items and services for persons with disabilities, older individuals with functional limitations, and low-income individuals, as determined by the Secretary.

(15) Licensed counseling services.—Services provided by a licensed marriage and family therapist or a licensed mental health counselor.

(16) Home- and community-based long-term care services and supports.—Home- and community-based long-term care services and supports (to be provided in accordance with the requirements for home and community-based settings under sections 441.530 and 441.710 of title 42, Code of Federal Regulations (as in effect July 4, 2026)), including—

(A) services described in paragraphs (7), (8), (13), (19), and (24) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a));

(B) home and community-based services described in section 1915(c)(4)(B) of the Social Security Act (42 U.S.C. 1396n(c)(4)(B)) (including habilitation services defined in subsection (c)(5) of such section);

(C) self-directed home and community-based services described in section 1915(i) of the Social Security Act;

(D) self-directed personal assistance services (as defined in section 1915(j)(4)(A) of the Social Security Act); and

(E) home and community-based attendant services and supports described in subsection (k) of section 1915 of the Social Security Act.

(17) Telehealth.—Any item or service described in any of paragraphs (1) through (16) that is furnished using telehealth, to the extent practicable.

(b) Revision.—The Secretary shall, at least on an annual basis, evaluate whether the benefits package should be improved to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to Congress regarding any such improvements.

(c) Complementary and integrative medicine.—

(1) In general.—In carrying out subsection (b), the Secretary shall consult with the persons described in paragraph (2) with respect to—

(A) identifying specific complementary and integrative medicine practices that are appropriate to include in the benefits package; and

(B) identifying barriers to the effective provision and integration of such practices into the delivery of health care, and identifying mechanisms for overcoming such barriers.

(2) Consultation.—In accordance with paragraph (1), the Secretary shall consult with—

(A) the Director of the National Center for Complementary and Integrative Health;

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and integrative medicine and the integration of such practices into the delivery of health care;

(D) nationally recognized providers of complementary and integrative medicine; and

(E) such other officials, entities, and individuals with expertise on complementary and integrative medicine as the Secretary determines appropriate.

(d) States may provide additional benefits.—A State may provide additional benefits for residents of such State, as determined by such State, and may provide benefits to individuals not eligible for benefits under the Medicare for All Program at the expense of the State.

(e) No patient cost-sharing.—

(1) In general.—The Secretary shall ensure that no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, is imposed on an individual for any benefit provided under the Medicare for All Program, except as described in paragraph (2).

(2) Exceptions.—The Secretary may set a cost-sharing schedule for prescription drugs covered under the Medicare for All Program—

(A) provided that—

(i) such schedule is evidence-based, patient-centered, and encourages the use of generic drugs;

(ii) such cost-sharing does not apply to preventive drugs;

(iii) such cost-sharing does not exceed $1,200 annually per individual, adjusted annually for inflation; and

(iv) such cost-sharing is not imposed on individuals with a household income equal to or below 250 percent of the poverty line for a family of the size involved; and

(B) under which the Secretary may—

(i) exempt brand-name drugs from consideration in determining whether an individual has reached any out-of-pocket limit if a safe and appropriate generic version of such drug is available to such individual; and

(ii) waive cost-sharing in response to a coverage appeal under subsection (f)(2).

(3) No balance billing.—Notwithstanding contracts in accordance with section 323(c), no provider may impose a charge to an individual enrolled for benefits under the Medicare for All Program for items and services for which benefits are provided under such Program.

(f) Exclusions and limitations.—

(1) In general.—Benefits for items and services are not available under the Medicare for All Program unless the items and services meet the standards developed by the Secretary pursuant to subsection (a).

(2) Treatment of experimental items and services.—

(A) In general.—In applying paragraph (1), the Secretary shall make national coverage determinations with respect to items and services that are experimental in nature. Such determinations shall be consistent with the national coverage determination process as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

(B) Appeals process.—The Secretary shall establish a process by which individuals can appeal coverage decisions. The process shall, as much as is feasible, follow the

process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

(3) Application of practice guidelines.—

(A) In general.—In the case of items and services for which the Department of Health and Human Services has recognized a national practice guideline, such items and services are considered to meet the standards specified in subsection (a) if they have been provided in accordance with such guideline.

(B) Certain exceptions.—For purposes of this paragraph, an item or service not provided in accordance with a national practice guideline shall be considered to have been provided in accordance with such guideline if the health care provider providing the item or service—

(i) exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline;

(ii) acted in accordance with the laws and requirements in which such item or service is furnished;

(iii) acted in the best interests of the individual receiving the item or service; and

(iv) acted in a manner consistent with the individual's wishes.

(g) Continued coverage of institutional long-term care and other services under Medicaid.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting the following section after section 1948:

"SEC. 1949. State plan for providing institutional long-term care services.

"(a) In general.—For quarters beginning on or after January 1, 2029, notwithstanding any other provision of this title—

"(1) a State plan for medical assistance shall provide for making medical assistance available for institutional long-term care services in a manner consistent with this section; and

"(2) no payment to a State shall be made under this title with respect to expenditures incurred by the State in providing medical assistance on or after such date for services that are not—

"(A) institutional long-term care services; or

"(B) other services for which benefits are not available under the Medicare for All Program and which are furnished under a State plan for medical assistance which provided for medical assistance for such services on March 1, 2026.

"(b) Institutional long-term care services defined.—In this section, the term 'institutional long-term care services' means the following:

"(1) Nursing facility services for individuals 21 years of age or over described in subparagraph (A) of section 1905(a)(4).

"(2) Inpatient services for individuals 65 years of age or over provided in an institution for mental disease described in section 1905(a)(14).

"(3) Intermediate care facility services described in section 1905(a)(15).

"(4) Inpatient psychiatric hospital services for individuals under age 21 described in section 1905(a)(16).

"(5) Nursing facility services described in section 1905(a)(31).

"(c) State maintenance of effort requirement.—

"(1) Eligibility standards.—

"(A) In general.—Beginning on the date described in subsection (a), no payment may be made under section 1903 with respect to medical assistance provided under a State plan for medical assistance if the State adopts income, resource, or other standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan that are more restrictive than those applied as of January 1, 2026.

"(B) Indexing of amounts of income and resource standards.—In determining whether a State has adopted income or resource standards that are more restrictive than the standards which applied as of January 1, 2026, the Secretary shall deem the amount of any such standard that was applied as of such date to be increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of 2025 to September of the fiscal year for which the Secretary is making such determination.

"(2) Expenditures.—

"(A) In general.—For each fiscal year or portion of a fiscal year that occurs during the period that begins on the first day of the first fiscal quarter that begins on or after January 1, 2029, as a condition of receiving payments under section 1903(a), a State shall make expenditures for medical assistance for institutional long-term care services in an amount that is not less than the expenditure floor determined for the State and fiscal year (or portion of a fiscal year) under subparagraph (B).

"(B) Expenditure floor.—

"(i) In general.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall determine for each State an expenditure floor that shall be equal to—

"(I) the amount of the State's expenditures for fiscal year 2026 on medical assistance for institutional long-term care services; increased by

"(II) the growth factor determined under subclause (ii).

"(ii) Growth factor.—For each fiscal year or portion of a fiscal year described in subparagraph (A), the Secretary shall, not later than September 1 of the fiscal year preceding such fiscal year or portion of a fiscal year, determine a growth factor for each State that takes into account—

"(I) the percentage increase in health care costs in the State;

"(II) the total amount expended by the State for the previous fiscal year on medical assistance for institutional long-term care services;

"(III) the increase, if any, in the total population of the State from July of 2026 to July of the fiscal year preceding the fiscal year involved;

"(IV) the increase, if any, in the population of individuals aged 65 and older of the State from July of 2026 to July of the fiscal year preceding the fiscal year involved; and

"(V) the decrease, if any, in the population of the State that requires medical assistance for institutional long-term care services that is attributable to the availability of coverage for the services described in section 322(a)(16).

"(iii) Proration rule.—Any amount determined under this subparagraph for a portion of a fiscal year shall be prorated based on the length of such portion of a fiscal year relative to a complete fiscal year.

"(d) Nonapplication of certain requirements.—Beginning on the date described in subsection (a), any provision of this title requiring a State plan for medical assistance to make available medical assistance for services that are not institutional long-term care services or items and services described in section 328(d)(1)(C)(i)(II) of the POPULIST Act shall have no effect.".

(h) Prohibiting recovery of correctly paid Medicaid benefits.—Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended—

(1) by amending subsection (a) to read as follows:

"(a) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual."; and

(2) by amending subsection (b) to read as follows:

"(b) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made.".

(i) Additional State standards.—

(1) In general.—Nothing in this subtitle shall prohibit a State from setting additional standards related to eligibility, benefits, and minimum provider standards, consistent with the purposes of this subtitle, provided that such standards do not restrict eligibility or reduce access to benefits for items and services.

(2) Restrictions on providers.—With respect to any individuals or entities certified to provide items and services covered under subsection (a)(7), a State may not prohibit an individual or entity from participating in the Medicare for All Program for reasons other than the inability of the individual or entity to provide such items and services.

SEC. 323. PROVIDER PARTICIPATION AND STANDARDS; WHISTLEBLOWER PROTECTIONS; PRIVATE CONTRACTS.

(a) Provider participation and standards; whistleblower protections.

(1) In general.—An individual or entity furnishing any item or service covered under the Medicare for All Program is not a participating provider under such Program unless the individual or entity—

(A) is a qualified provider of the items or services under subsection (b);

(B) has filed with the Secretary a participation agreement described in paragraph (2); and

(C) meets, as applicable, such other qualifications and conditions with respect to a provider of services under title XVIII of the Social Security Act as described in section 1866 of the Social Security Act (42 U.S.C. 1395cc).

(2) Requirements in participation agreement.—

(A) In general.—A participation agreement described in this paragraph between the Secretary and a provider shall provide at least for the following:

(i) Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 324(a). Nothing in this clause shall be construed as requiring the provision of a type or class of items or services that are outside the scope of the provider’s normal practice.

(ii) No charge will be made to any enrolled individual for any items or services covered under the Medicare for All Program other than for payment authorized by this subtitle.

(iii) The provider agrees to furnish such information as may be reasonably required by the Secretary, in accordance with uniform reporting standards established under section 324(a)(2)(A), for—

(I) quality review;

(II) making payments under this subtitle, including the examination of records as may be necessary for the verification of information on which such payments are based;

(III) statistical or other studies required for the implementation of this subtitle; and

(IV) such other purposes as the Secretary may specify.

(iv) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health care items or services any individual or other provider that has had a participation agreement under this paragraph terminated for cause. The Secretary may authorize such employment or use on a case-by-case basis.

(v) In the case of a provider paid under a fee-for-service basis for items and services furnished under the Medicare for All Program, the provider agrees to submit bills and any required supporting documentation relating to the provision of items or services covered under such Program within 30 days after the date of providing such items and services.

(vi) In the case of an institutional provider paid pursuant to section 326(c), the provider agrees to submit information and any other required supporting documentation as may be reasonably required by the Secretary within 30 days after the date of providing items and services covered under the Medicare for All Program and in accordance with the uniform reporting standards established under section 324(a)(2)(B), including information on a quarterly basis that—

(I) relates to the provision of items and services covered under the Medicare for All Program; and

(II) describes such items and services furnished with respect to specific individuals.

(vii) In the case of a provider that receives payment for items and services furnished under the Medicare for All Program based on diagnosis-related coding, procedure coding, or other coding system or data, the provider agrees—

(I) to disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations under section 326 or for

meeting any other payment, documentation, or data collection requirements under this subtitle; and

(II) not to use any such system or index to establish financial incentives or disincentives for health care professionals, or that is proprietary, interferes with the medical or nursing process, or is designed to increase the amount or number of payments.

(viii) The provider complies with the duty of provider ethics and reporting requirements described in subparagraph (B).

(ix) In the case of a provider that is not an individual, the provider agrees that no board member, executive, or administrator of such provider receives compensation from, owns stock or has other financial investments in, or serves as a board member of any entity that contracts with or provides items or services, including pharmaceutical products and medical devices or equipment, to such provider.

(B) Provider duty of ethics.—Each health care provider, including institutional providers, has a duty to advocate for and to act in the exclusive interest of each individual under the care of such provider according to the applicable legal standard of care, such that no financial interest or relationship impairs any health care provider's ability to furnish necessary and appropriate care to such individual. To implement the duty established in this paragraph, the Secretary shall—

(i) promulgate reasonable reporting rules to evaluate participating provider compliance with this paragraph;

(ii) prohibit participating providers, spouses, and immediate family members of participating providers, from accepting or entering into any arrangement for any bonus, incentive payment, profit-sharing, or compensation based on patient utilization or based on financial outcomes of any other provider or entity; and

(iii) prohibit participating providers or any board member or representative of such provider from serving as board members for or receiving any compensation, stock, or other financial investment in an entity that contracts with or provides items or services (including pharmaceutical products and medical devices or equipment) to such provider.

(C) Termination of participation agreement.—

(i) In general.—Participation agreements may be terminated, with appropriate notice—

(I) by the Secretary for failure to meet the requirements of this subtitle;

(II) in accordance with the provisions described in section 324(f); or

(III) by a provider.

(ii) Termination process.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Secretary terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

(iii) Provider protections.—

(I) Prohibition.—The Secretary may not terminate a participation agreement or in any other way discriminate against, or cause to be discriminated against, any participating provider described in paragraph (1) or authorized representative of the provider, on account of such provider or representative—

(aa) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this subtitle;

(bb) testifying or being about to testify in a proceeding concerning such violation;

(cc) assisting or participating, or being about to assist or participate, in such a proceeding; or

(dd) objecting to, or refusing to participate in, any activity, policy, practice, or assigned task that the provider or representative reasonably believes to be in violation of any provision of this subtitle (including any amendment made by this subtitle), or any order, rule, regulation, standard, or ban under this subtitle (including any amendment made by this subtitle).

(II) Complaint procedure.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(3) Whistleblower protections.—

(A) Retaliation prohibited.—No person may discharge or otherwise discriminate against any employee because the employee or any person acting pursuant to a request of the employee—

(i) notified the Secretary or the employee's employer of any alleged violation of this subtitle, including communications related to carrying out the employee's job duties;

(ii) refused to engage in any practice made unlawful by this subtitle, if the employee has identified the alleged illegality to the employer;

(iii) testified before or otherwise provided information relevant for Congress or for any Federal or State proceeding regarding any provision (or proposed provision) of this subtitle;

(iv) commenced, caused to be commenced, or is about to commence or cause to be commenced a proceeding under this subtitle;

(v) testified or is about to testify in any such proceeding; or

(vi) assisted or participated or is about to assist or participate in any manner in such a proceeding or in any other manner in such a proceeding or in any other action to carry out the purposes of this subtitle.

(B) Enforcement action.—Any employee covered by this paragraph who alleges discrimination by an employer in violation of subparagraph (A) may bring an action, subject to the statute of limitations described in section 3730(h)(3) of title 31, United States Code, and the rules and procedures, legal burdens of proof, and remedies applicable under section 31105 of title 49, United States Code.

(C) Application.—

(i) Nothing in this paragraph shall be construed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or regulation, including the rights and remedies against retaliatory action under section 3730(h) of title 31, United States Code, or under any collective bargaining agreement. The rights and remedies in this paragraph may not be waived by any agreement, policy, form, or condition of employment.

(ii) Nothing in this paragraph shall be construed to preempt or diminish any other Federal or State law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination, including the rights and remedies against retaliatory action under section 3730(h) of title 31, United States Code.

(D) Definitions.—In this paragraph:

(i) Employer.—The term “employer” means any person engaged in profit or a nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organizations including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and subject to liability for violating the provisions of this subtitle.

(ii) Employee.—The term “employee” means any individual performing activities under this subtitle on behalf of an employer.

(b) Qualifications for providers.—

(1) In general.—A health care provider is considered a qualified provider to furnish items and services under the Medicare for All Program if the provider is licensed or certified to furnish such items and services in the State in which the individual receiving such items and services is located and meets—

(A) the requirements of such State's laws to furnish such items and services; and

(B) applicable requirements of Federal law to furnish such items and services.

(2) Federal providers.—Any provider qualified to provide health care items and services at a facility of the Department of Veterans Affairs, the Indian Health Service, or the uniformed services (as defined in section 1072(1) of title 10, United States Code) (with respect to the direct care component of the TRICARE program) is a qualified provider under this subsection with respect to any individual who qualifies for such items and services under applicable Federal law.

(3) Minimum provider standards.—

(A) In general.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of items and services provided under the Medicare for All Program and to monitor efforts by States to ensure the quality of such items and services. A State may also establish additional minimum standards which providers shall meet with respect to items and services provided in such State.

(B) National minimum standards.—The Secretary shall establish national minimum standards under subparagraph (A) for institutional providers of items or services and individual health care practitioners. Except as the Secretary may specify in order to carry out this subtitle, a hospital, skilled nursing facility, or other institutional provider of items or services shall meet standards applicable to such a provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

(i) adequacy and quality of facilities;

(ii) training and competence of personnel (including requirements related to the number or type of required continuing education hours);

(iii) comprehensiveness of items and services;

(iv) continuity of items and services;

(v) patient waiting times, access to items and services, and references; and

(vi) performance standards, including organization, facilities, structure of items and services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation.

(C) Transition in application.—If the Secretary provides for additional requirements for providers under this paragraph, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(c) Use of private contracts.—

(1) In general.—This subsection shall apply beginning on the date on which benefits are first available under section 321(f)(1). Subject to the provisions of this subsection, nothing in this subtitle shall prohibit an institutional or individual provider from entering into a private contract with an individual enrolled for benefits under the Medicare for All Program for any item or service—

(A) for which no claim for payment is to be submitted under this subtitle; and

(B) for which the provider receives—

(i) no reimbursement under this subtitle directly or on a capitated basis; and

(ii) receives no amount from an organization which receives reimbursement for such item or service under this subtitle directly or on a capitated basis.

(2) Contract requirements.—

(A) In general.—Any contract to provide an item or service under paragraph (1) shall—

(i) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(ii) be entered into at a time when the individual is facing an emergency health care situation; and

(iii) contain the items described in subparagraph (B).

(B) Items required to be included in contract.—Any contract to provide an item or service to which paragraph (1) applies shall clearly indicate to the individual that by signing such contract the individual—

(i) agrees not to submit a claim (or to request that the provider submit a claim) under this subtitle for such item or service even if such item or service is otherwise covered by the Medicare for All Program;

(ii) agrees to be responsible, whether through insurance offered under section 107(b) or otherwise, for payment of such item or service and understands that no reimbursement will be provided under this subtitle for such item or service;

(iii) acknowledges that no limits under this subtitle apply to amounts that may be charged for such item or service;

(iv) if the provider is a nonparticipating provider, acknowledges that the beneficiary has the right to have such item or service provided by other providers for whom payment would be made under the Medicare for All Program; and

(v) acknowledges that the provider is providing an item or service outside the scope of the Medicare for All Program.

(3) Provider requirements.—

(A) In general.—Paragraph (1) shall not apply to any contract unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) Affidavit.—An affidavit as described in this subparagraph shall—

(i) identify the provider, and be signed by such provider;

(ii) provide that the provider will not submit any claim under this subtitle for any item or service provided to any beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 1-year period beginning on the date the affidavit is signed; and

(iii) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(C) Enforcement.—If a provider signing an affidavit described in subparagraph (B) knowingly and willfully submits a claim under this subtitle for any item or service provided during the 1-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

(i) this paragraph shall not apply with respect to any item or service provided by the provider pursuant to any contract on and after the date of such submission and before the end of such period; and

(ii) no payment shall be made under this subtitle for any item or service furnished by the provider during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

SEC. 324. ADMINISTRATION; CONSULTATION; REGIONAL ADMINISTRATION; BENEFICIARY OMBUDSMAN; FRAUD AND ABUSE CONTROL.

(a) Administration.

(1) General duties of the Secretary.—

(A) In general.—The Secretary shall develop policies, procedures, guidelines, and requirements to carry out this subtitle, including related to—

(i) eligibility for benefits under the Medicare for All Program;

(ii) enrollment under such Program;

(iii) benefits provided under such Program;

(iv) provider participation standards and qualifications, as described in section 323;

(v) levels of funding;

(vi) methods for determining amounts of payments to providers of items and services covered under the Medicare for All Program, consistent with section 324(f);

(vii) a process for appealing or petitioning for a determination of coverage for items and services under the Medicare for All Program;

(viii) planning for capital expenditures and item and service delivery;

(ix) planning for health professional education funding;

(x) encouraging States to develop regional planning mechanisms; and

(xi) any other regulations necessary to carry out the purposes of this subtitle.

(B) Regulations.—Regulations authorized by this subtitle shall be issued by the Secretary in accordance with section 553 of title 5, United States Code.

(2) Uniform reporting standards; annual report; studies.—

(A) Uniform reporting standards.—

(i) In general.—The Secretary shall establish uniform State reporting requirements, provider reporting requirements, and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and services covered under the Medicare for All Program, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures used under this subtitle, and to the maximum extent feasible without excessively burdening providers, the measures described in clauses (iv) through (vi) of subparagraph (B).

(ii) Reports.—The Secretary shall—

(I) regularly analyze information reported to the Secretary; and

(II) define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

(B) Annual report.—Beginning January 1 of the second year beginning after the date on which benefits are first available under section 321(f)(1), the Secretary shall annually report to Congress on the following:

(i) The status of implementation of this subtitle.

(ii) Enrollment under the Medicare for All Program.

(iii) Benefits under the Medicare for All Program.

(iv) Expenditures and financing under this subtitle.

(v) Cost-containment measures and achievements under the Medicare for All Program.

(vi) Quality assurance.

(vii) Health care utilization patterns, including any changes attributable to the Medicare for All Program.

(viii) Changes in the per capita costs of health care.

(ix) Differences in the health status of the populations of the different States, by demographic characteristics, including race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

(x) Progress on implementing quality and outcome measures under this subtitle, and long-range plans and goals for achievements in such measures.

(xi) Plans for improving items and services to medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(xii) Transition problems as a result of implementation of this subtitle.

(xiii) Opportunities for improvements under this subtitle.

(C) Statistical analyses and other studies.—The Secretary may, either directly or by contract—

(i) make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this subtitle;

(ii) develop and test methods of delivery of items and services as the Secretary may consider necessary or promising for the evaluation, or for the improvement, of the operation of this subtitle; and

(iii) develop methodological standards for evidence-based policymaking.

(3) Audits.—

(A) In general.—The Comptroller General of the United States shall conduct an audit of the Department of Health and Human Services every fifth fiscal year following the date on which benefits are first available under section 321(f)(1) to determine the effectiveness of the Medicare for All Program in carrying out the duties under paragraph (1).

(B) Reports.—The Comptroller General of the United States shall submit a report to Congress concerning the results of each audit conducted under this paragraph.

(b) Consultation.—The Secretary shall consult with Federal agencies, Indian Tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic health centers, consumer groups, patient advocate groups, disability rights organizations, and labor business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this subtitle. Nothing in this subtitle shall prevent the Secretary from adopting guidelines, consistent with section 322(f)(3), developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this subtitle.

(c) Regional administration.

(1) Regional Medicare for All offices.—The Secretary shall establish and maintain regional offices for the purpose of carrying out the duties specified in paragraph (4) and promoting adequate access to, and efficient use of, tertiary care facilities, equipment, items, and services by individuals enrolled under the Medicare for All Program.

(2) Coordination.—Wherever possible, the Secretary shall incorporate the regional offices and the administrative processes of the Centers for Medicare & Medicaid Services for the purposes of carrying out paragraph (1).

(3) Appointment of regional directors.—In each regional office established under paragraph (1) there shall be—

(A) one regional director appointed by the Secretary;

(B) one deputy director appointed by the regional director to represent the Indian and Alaska Native Tribes in the region, if any; and

(C) one deputy director appointed by the regional director to oversee home- and community-based services and supports.

(4) Duties.—Each regional director shall—

(A) submit an annual regional health care needs assessment report to the Secretary;

(B) recommend any changes in provider reimbursement or payment for delivery of items and services covered under the Medicare for All Program determined appropriate by the regional director, subject to the requirements of section 326; and

(C) establish a quality assurance mechanism in each such region to minimize underutilization and overutilization of health care items and services and to ensure that all participating providers described in section 323(a)(1) meet applicable standards.

(d) Beneficiary Ombudsman.

(1) In general.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education and in providing assistance to individuals entitled to benefits under the Medicare for All Program.

(2) Duties.—

(A) In general.—The Beneficiary Ombudsman shall—

(i) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under the Medicare for All Program with respect to any aspect of such Program;

(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

(I) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

(II) assistance to such individuals in presenting information relating to cost-sharing; and

(iii) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this subtitle as the Ombudsman determines appropriate.

(B) Authorities.—The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of items or services, but may identify issues and problems in payment or coverage policies.

(e) Conduct of related health programs.—In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance,

vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions complementary to this subtitle.

(f) Fraud and abuse control.—The following sections of the Social Security Act shall apply to the Medicare for All Program in the same manner as they apply to State medical assistance plans under title XIX of such Act (42 U.S.C. 1396 et seq.):

(1) Section 1128 (42 U.S.C. 1320a–7) (relating to exclusion of individuals and entities).

(2) Section 1128A (42 U.S.C. 1320a–7a) (civil monetary penalties).

(3) Section 1128B (42 U.S.C. 1320a–7b) (criminal penalties).

(4) Section 1124 (42 U.S.C. 1320a–3) (relating to disclosure of ownership and related information).

(5) Section 1126 (42 U.S.C. 1320a–5) (relating to disclosure of certain owners).

(6) Section 1877 (42 U.S.C. 1395nn) (relating to physician referrals).

SEC. 325. QUALITY STANDARDS AND HEALTH CARE DISPARITIES.

(a) Quality standards.

(1) In general.—All standards and quality measures under this subtitle shall be implemented and evaluated by the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this section as the “Center”) or such other agencies determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

(2) Duties of the Center.—The Center shall perform the following duties:

(A) Review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299b et seq.). In so reviewing and evaluating, the Center shall determine whether the guideline should be recognized as a national practice guideline in accordance with and subject to section 322(f)(3).

(B) Review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299b et seq.). In so reviewing and evaluating, the Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of items and services provided by health care institutions or health care professionals. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments. The Center shall consider the evidentiary basis for the standard, and the validity, reliability, and feasibility of measuring the standard.

(C) Adoption of methodologies for profiling the patterns of practice of health care professionals and for identifying and notifying outliers.

(D) Development of minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality reviews in the administrative regions. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the region and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Center shall ensure coordination and reporting by such entities to ensure national consistency in quality standards.

(E) Submission of a report to the Secretary annually specifically on findings from outcomes research and development of practice guidelines that may affect the Secretary's determination of coverage of items and services under section 324(a)(1)(A)(vii).

(b) Addressing health care disparities.

(1) Evaluating data collection approaches.—The Center, in coordination with the Office of Health Equity established under section 1712 of the Public Health Service Act (42 U.S.C. 300u-11) and other agencies in the Department of Health and Human Services determined relevant by the Secretary, shall evaluate approaches for the collection of data under this subtitle, to be performed in conjunction with existing quality reporting requirements and programs under this subtitle, that allow for the ongoing, accurate, and timely collection of data on disparities in health care items and services and performance on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status. In conducting such evaluation, the Center shall consider the following objectives:

(A) Protecting patient privacy.

(B) Minimizing the administrative burdens of data collection and reporting on providers under the Medicare for All Program.

(C) Improving data on race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, and socioeconomic status.

(2) Reports to Congress.

(A) Report on evaluation.—Not later than July 1, 2030, the Center shall submit to Congress and the Secretary a report on the evaluation conducted under paragraph (1). Such report shall, taking into consideration the results of such evaluation—

(i) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender

identity and sexual orientation), geography, or socioeconomic status under the Medicare for All Program; and

(ii) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

(B) Report on data analyses.—Beginning in 2031, not later than December 31 of every odd-numbered year, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under paragraph (3).

(3) Implementing effective approaches.—Not later than January 1, 2031, the Secretary shall implement the approaches identified in the report submitted under paragraph (2)(A) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

SEC. 326. NATIONAL HEALTH BUDGET; TEMPORARY WORKER ASSISTANCE; PAYMENTS TO PROVIDERS; OFFICE OF HEALTH EQUITY; OFFICE OF PRIMARY HEALTH CARE.

(a) National health budget.—

(1) National health budget.—

(A) In general.—Not later than September 1 of each year, beginning with the year prior to the date on which benefits are first available under section 321(f), the Secretary shall establish a national health budget, which specifies a budget for the total expenditures to be made for items and services covered under the Medicare for All Program.

(B) Division of budget into components.—The national health budget shall consist of at least the following components:

(i) An operating budget.

(ii) A capital expenditures budget.

(iii) A special projects budget.

(iv) Quality assessment activities under section 325.

(v) Health professional education expenditures.

(vi) Administrative costs, including costs related to the operation of regional offices.

(vii) A reserve fund.

(viii) Prevention and public health activities.

(C) Allocation among components.—The Secretary shall allocate the funds received for purposes of carrying out this subtitle among the components described in subparagraph (B) in a manner that ensures—

(i) that the operating budget allows for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations;

(ii) that the special projects budget is sufficient to meet the health care needs within areas described in subparagraph (G) through the construction, renovation, and staffing of health care facilities in a reasonable timeframe;

(iii) a fair allocation for quality assessment activities; and

(iv) that the health professional education expenditure component described in subparagraph (B)(v) is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for items and services covered under the Medicare for All Program.

(D) For regional allocation.—The Secretary shall annually provide each regional office with an allotment the Secretary determines appropriate for purposes of carrying out this subtitle in such region, including payments to providers in such region, capital expenditures in such region, special projects in such region, health professional education in such region, administrative expenses in such region, and prevention and public health activities in such region.

(E) Operating budget.—The operating budget described in subparagraph (B)(i) shall be used for—

(i) payments to institutional providers pursuant to subsection (c); and

(ii) payments to individual providers pursuant to subsection (d).

(F) Capital expenditures budget.—The capital expenditures budget described in subparagraph (B)(ii) shall be used for—

(i) the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term care services and support; and

(ii) major equipment purchases.

(G) Special projects budget.—The special projects budget described in subparagraph (B)(iii) shall be used for the purposes of allocating funds for the construction of new facilities, major equipment purchases, and staffing in rural areas or areas described in section 330(b)(3) of the Public Health Service Act (42 U.S.C.

254b(b)(3)), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))), and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

(H) Reserve fund.—The reserve fund described in subparagraph (B)(vii) shall be used to respond to the costs of an epidemic, pandemic, natural disaster, or other such health emergency, or market-shift adjustments related to patient volume.

(I) Construction compliance.—Expenditures from each component of the national health budget, including construction, shall expand accessibility for persons with disabilities to achieve full compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.). Any project funded through the national budget shall at least meet the new construction standards under such Act.

(2) Definitions.—In this subsection:

(A) Capital expenditures.—The term "capital expenditures" means expenses for the purchase, lease, construction, or renovation of capital facilities and for major equipment.

(B) Health professional education expenditures.—The term "health professional education expenditures" means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities, including the impact of workforce recruitment, retention, and diversity on patient outcomes.

(b) Temporary worker assistance.—

(1) In general.—For up to 5 years following the date on which benefits are first available under section 321(f), at least 1 percent of the national health budget shall be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system, or related functions within health care institutions or organizations, who may experience economic dislocation as a result of the implementation of this subtitle.

(2) Clarification.—Assistance described in paragraph (1) shall include wage replacement, retirement benefits, job training and placement, preferential hiring, and education benefits.

(c) Payments to institutional providers based on global budgets.—

(1) In general.—Not later than the beginning of each fiscal quarter during which an institutional provider of care (including hospitals, skilled nursing facilities, and independent dialysis facilities) is to furnish items and services under the Medicare for All Program, the Secretary shall pay to such institutional provider a lump sum in accordance with the succeeding provisions of this paragraph and consistent with the following:

(A) Payment in full.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under the Medicare for All Program,

whether inpatient or outpatient, by such provider for such quarter, including outpatient or any other care provided by the institutional provider or provided by any health care provider who provided items and services pursuant to an agreement paid through the global budget as described in subparagraph (C).

(B) Quarterly review.—The regional director, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and shall determine whether adjustments to such institutional provider's payment are warranted. This review shall include consideration for additional funding necessary for unanticipated items and services for individuals with complex medical needs or market-shift adjustments related to patient volume, and an assessment of any adjustments made to ensure that accuracy and need for adjustment was appropriate.

(C) Agreements for salaried payments for certain providers.—

(i) In general.—Certain group practices and other health care providers, as determined by the Secretary, with agreements to provide items and services at a specified institutional provider paid a global budget under this paragraph may elect to be paid through such institutional provider's global budget in lieu of payment under subsection (d).

(ii) Salaries.—Any individual health care professional of such group practice or other provider receiving payment through an institutional provider's global budget under this subparagraph shall be paid on a salaried basis that is equivalent to salaries or other compensation rates negotiated for individual health care professionals of such institutional provider.

(iii) Reporting and disclosure requirements.—Any group practice or other health care provider that receives payment through an institutional provider's global budget under this subparagraph shall be subject to the same reporting and disclosure requirements of the institutional provider.

(D) Interim adjustments.—The regional director shall consider a petition for adjustment of any payment under this subsection filed by an institutional provider at any time based on the following:

(i) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the institutional provider, such as—

(I) natural disasters;

(II) public health emergencies including outbreaks of epidemics or infectious diseases;

(III) unexpected facility or equipment repairs or purchases;

(IV) significant and unexpected increases in pharmaceutical or medical device prices;

(V) unanticipated increases in complex or high-cost patients or care needs.

(ii) Changes in Federal or State law that result in a change in costs.

(iii) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wages, or local law.

(2) Payment amount.—

(A) In general.—The amount of each payment to a provider described in paragraph (1) shall be determined before the start of each calendar year through negotiations between the provider and the regional director with jurisdiction over such provider. Such amount shall be based on factors specified in subparagraph (B).

(B) Payment factors.—Payments negotiated pursuant to subparagraph (A) shall take into account, with respect to a provider—

(i) the historical volume of items and services provided for each item and service in the previous 3-year period;

(ii) the actual expenditures of such provider in such provider's most recent cost report under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for each item and service compared to—

(I) such expenditures for other institutional providers in the director's jurisdiction;

(II) normative payment rates established under comparative payment rate systems, including any adjustments, for such items and services;

(iii) projected changes in the volume and type of items and services to be furnished;

(iv) wages for employees, including any necessary increases to ensure mandatory minimum safe registered nurse-to-patient ratios and optimal staffing levels for physicians and other health care workers;

(v) the provider's maximum capacity to provide items and services;

(vi) education and prevention programs;

(vii) permissible adjustment to the provider's operating budget due to factors such as—

(I) an increase in primary or specialty care access;

(II) efforts to decrease health care disparities in rural areas or areas described in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a));

(III) a response to emergent epidemic conditions;

(IV) an increase in complex or high-cost patients or care needs; or

(V) proposed new and innovative patient care programs at the institutional level;

(viii) whether the provider is located in a county or census tract with an overall CDC/ATSDR Social Vulnerability Index percentile rank of 0.75 or higher; and

(ix) any other factor determined appropriate by the Secretary.

(C) Limitation.—Payment amounts negotiated pursuant to subparagraph (A) may not—

(i) take into account capital expenditures of the provider or any other expenditure not directly associated with the provision of items and services by the provider to an individual;

(ii) be used by a provider for capital expenditures or such other expenditures;

(iii) exceed the provider's capacity to provide care under the Medicare for All Program; or

(iv) be used to pay or otherwise compensate any board member, executive, or administrator of the institutional provider who has any interest or relationship prohibited under section 323(a)(2)(B).

(D) Limitation on compensation.—Compensation costs for any employee or any contractor or any subcontractor employee of an institutional provider receiving global budgets under this subsection shall not exceed the compensation cap established in section 4304(a)(16) of title 41, United States Code, as added by section 702 of the Bipartisan Budget Act of 2013, and implementing regulations.

(E) Regional negotiations permitted.—Subject to subsection (f), a regional director may negotiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market shifts related to patient volume.

(3) Baseline rates and adjustments.—

(A) In general.—The Secretary shall use existing prospective payment systems under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to serve as the

comparative payment rate system in global budget negotiations described in paragraph (2). The Secretary shall update such comparative payment rate systems annually.

(B) Specifications.—In developing the comparative payment rate system, the Secretary shall use only the operating base payment rates under each such prospective payment systems with applicable adjustments.

(C) Limitation.—The comparative rate system established under this subsection shall not include the value-based payment adjustments and the capital expenses base payment rates that may be included in such a prospective payment system.

(D) Initial year.—In the first year that global budget payments under this subtitle are available to institutional providers and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for each institutional provider, the Secretary shall take into account the appropriate prospective payment system from the most recent year under title XVIII of the Social Security Act to determine what operating base payment the institutional provider would have been paid for items and services covered under the Medicare for All Program furnished the preceding year with applicable adjustments, including adjustments due to any public health emergencies in the preceding year, and excluding value-based payment adjustments, based on such prospective payment system.

(4) Operating expenses.—For purposes of this section, "operating expenses" of a provider include the following:

(A) The cost of all items and services associated with the provision of inpatient care and outpatient care, including the following:

(i) Wages and salary costs for physicians, nurses, and other health care practitioners employed by an institutional provider, including mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other health care workers.

(ii) Wages and salary costs for all ancillary staff and services.

(iii) Costs of all pharmaceutical products administered by health care clinicians at the institutional provider's facilities or through items or services provided in accordance with State licensing laws or regulations under which the institutional provider operates.

(iv) Costs for infectious disease response preparedness, including maintenance of a 1-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, medical items and services for occupational infectious disease exposure, and contact tracing.

(v) Purchasing and maintenance of medical devices, supplies, and other health care technologies, including diagnostic testing equipment.

(vi) Costs of all incidental items and services necessary for safe patient care and handling.

(vii) Costs of patient care, education, and prevention programs, including occupational health and safety programs, public health programs, and necessary staff to implement such programs, for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(B) Administrative costs for the institutional provider.

(d) Payments to individual providers through fee-for-service.—

(1) Medicare for All fee schedule.—

(A) Establishment.—Not later than January 1, 2028, and in consultation with providers and regional office directors, the Secretary shall establish and annually update a national fee schedule that establishes amounts for items and services payable under the Medicare for All Program, furnished by—

(i) individual providers;

(ii) providers in group practices who are not receiving payments on a salaried basis described in subsection (c)(1)(C);

(iii) providers of home- and community-based services; and

(iv) any other provider not described in subsection (c).

(B) Amounts.—In establishing the fee schedule under subparagraph (A), the Secretary shall take into account—

(i) the amounts payable for such items and services under title XVIII of the Social Security Act and other Federal health programs; and

(ii) the expertise of providers and the value of items and services furnished by such providers.

(2) Leveraging existing medicare payment processes.—

(A) Application of payment processes under title XVIII.—Except as otherwise provided in this subsection, the Secretary shall establish, and shall annually update by regulation, the fee schedule under paragraph (1) in a manner that is documented, is transparent, allows for public comment, and, to the greatest extent practicable, is consistent with processes for determining, revising, and making payments for items and services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including the application of the provisions of, and amendments made by, subsection (e).

(B) Electronic billing.—The Secretary shall establish a uniform national system for electronic billing for purposes of making payments under this subsection.

(3) Application of current and planned payment reforms.—To the extent the Secretary determines such application is necessary to ensure a smooth and fair transition, the Secretary may apply payment reform activities planned or implemented with respect to such title XVIII as of the date of the enactment of this Act, including demonstrations, waivers, or any other provider payment agreements, to benefits under the Medicare for All Program, provided that the Secretary sets forth a process for reviewing such applications and making such determinations that is reasonable, transparent, and documented, and allows for public comment.

(4) Physician practice review board.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician-delivered items and services. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments.

(e) Accurate valuation of services under the Medicare physician fee schedule.—

(1) Standardized and documented review process.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

"(P) Standardized and documented review process.—

"(i) In general.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall establish, document, and make publicly available, in consultation with the Office of Primary Health Care, a standardized process for reviewing the relative values of physicians' services under this paragraph.

"(ii) Minimum requirements.—The standardized process shall include, at a minimum, methods and criteria for identifying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying additional resources to be considered during the review process.".

(2) Planned and documented use of funds.—Section 1848(c)(2)(M) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(M)) is amended by adding at the end the following new clause:

"(x) Planned and documented use of funds.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.".

(3) Internal tracking of reviews.—

(A) In general.—Not later than July 1, 2027, the Secretary shall submit to Congress a proposed plan for systematically and internally tracking the Secretary's review of the relative values of physicians' services, such as by establishing an internal database, under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by this section.

(B) Minimum requirements.—The proposal shall include, at a minimum, plans and a timeline for achieving the ability to systematically and internally track the following:

(i) When, how, and by whom services are identified for review.

(ii) When services are reviewed or when new services are added.

(iii) The resources, evidence, data, and recommendations used in reviews.

(iv) When relative values are adjusted.

(v) The rationale for final relative value decisions.

(4) Frequency of review.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(i), by striking "5" and inserting "4"; and

(B) in subparagraph (K)(i)(I), by striking "periodically" and inserting "annually".

(5) Consultation with Medicare Payment Advisory Commission.—

(A) In general.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(i) in subparagraph (B)(i), by inserting "in consultation with the Medicare Payment Advisory Commission," after "The Secretary,"; and

(ii) in subparagraph (K)(i)(I), as amended by paragraph (4)(B), by inserting ", in coordination with the Medicare Payment Advisory Commission," after "annually".

(B) Conforming amendments.—Section 1805 of the Social Security Act (42 U.S.C. 1395b–6) is amended—

(i) in subsection (b)(1)(A), by inserting the following before the semicolon at the end: "and including coordinating with the Secretary in accordance with section 1848(c)(2) to systematically review the relative values established for physicians' services, identify potentially misvalued services, and propose adjustments to the relative values for physicians' services"; and

(ii) in subsection (e)(1), in the second sentence, by inserting "or the Ranking Minority Member" after "the Chairman".

(6) Periodic audit by the Comptroller General.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

"(Q) Periodic audit by the Comptroller General.—

"(i) In general.—The Comptroller General of the United States (in this subparagraph referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

"(ii) Access to information.—The Comptroller General shall have unrestricted access to all deliberations, records, and data related to the activities carried out under this paragraph, in a timely manner, upon request.".

(f) Payments for prescription drugs and approved devices and equipment.—

(1) Negotiated prices.—The prices to be paid for pharmaceutical products, medical supplies, and medically necessary assistive equipment covered under the Medicare for All Program shall be negotiated annually by the Secretary.

(2) Prescription drug formulary.—

(A) In general.—The Secretary shall establish a prescription drug formulary system, pursuant to the requirements of section 322(e)(2), which shall encourage best practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(B) Promotion of use of generics.—The formulary under this paragraph shall promote the use of generic medications to the greatest extent possible.

(C) Formulary updates and petition rights.—The formulary under this paragraph shall be updated frequently and clinicians and patients may petition the Secretary to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(D) Use of off-formulary medications.—The Secretary shall promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary.

(g) Payment prohibitions; capital expenditures; special projects.—

(1) Prohibitions.—Payments to participating providers described in section 323(a)(1) may not take into account, include any process for the provision of funding for, or be used by a provider for—

(A) marketing of the provider;

(B) the profit or net revenue of the provider, or increasing the profit or net revenue of the provider;

(C) any agreement or arrangement described in section 203(a)(4) of the Labor-Management Reporting and Disclosure Act of 1959 (29 U.S.C. 433(a)(4)); or

(D) political or other contributions prohibited under section 317(a)(1) of the Federal Election Campaign Act of 1971 (52 U.S.C. 30119(a)(1)).

(2) Payments for capital expenditures.—

(A) In general.—The Secretary shall pay, from amounts made available for capital expenditures pursuant to subsection (a)(1)(B)(ii), such sums determined appropriate by the Secretary to providers who have submitted an application to the regional director of the region or regions in which the provider operates or seeks to operate in a time and manner specified by the Secretary for purposes of funding capital expenditures of such providers.

(B) Priority.—The Secretary shall prioritize allocation of funding under subparagraph (A) to projects that propose to use such funds to improve items and services for medically underserved populations and areas described in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)) or to address socioeconomic health disparities.

(C) Limitation.—The Secretary shall not grant funding for capital expenditures under this paragraph for capital projects that are financed directly or indirectly through the diversion of private or other non-Medicare for All Program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

(D) Capital assets not funded by the Medicare for All Program.—Operating expenses and funds shall not be used by an institutional provider receiving payment for capital expenditures under this paragraph for a capital asset that was not funded by the Medicare for All Program without the approval of the regional director or directors of the region or regions where the capital asset is located.

(3) Prohibition against commingling operating and capital funds.—Providers that receive payment under this title shall be prohibited from using, with respect to funds made available under this subtitle—

(A) funds designated for operating expenditures for capital expenditures or for profit; or

(B) funds designated for capital expenditures for operating expenditures.

(4) Payments for special projects.—

(A) In general.—The Secretary shall allocate to each regional director, from amounts made available for special projects pursuant to subsection (a)(1)(B)(iii), such sums determined appropriate by the Secretary for purposes of funding projects described in such subsection, including the construction, renovation, or staffing of health care

facilities in rural, underserved, or health professional or medical shortage areas within such region and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

(B) Distribution.—A regional director shall distribute funds to providers operating in the region of such director's jurisdiction in a manner determined appropriate by the director.

(5) Prohibition on financial incentive metrics in payment determinations.—The Secretary may not utilize any quality metrics or standards for the purposes of establishing provider payment methodologies, programs, modifiers, or adjustments for provider payments under this title.

(h) Office of Health Equity.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following:

"SEC. 1712. Office of Health Equity.

"(a) In general.—There is established, in the Office of the Secretary of Health and Human Services, an Office of Health Equity, to be headed by a Director, to ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to ensuring health equity.

"(b) Monitoring, tracking, and availability of data.—

"(1) In general.—In carrying out subsection (a), the Director of the Office of Health Equity shall monitor, track, and make publicly available data on—

"(A) the disproportionate burden of disease and death among people of color, disaggregated by race, major ethnic group, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States, age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status;

"(B) barriers to health, including such barriers relating to income, education, housing, food insecurity (including availability, access, utilization, and stability), employment status, working conditions, and conditions related to the physical environment (including pollutants, population density, and accessibility);

"(C) barriers to health care access, including—

"(i) lack of trust and awareness;

"(ii) lack of transportation;

"(iii) lack of accessibility;

"(iv) geography;

"(v) hospital and service closures;

"(vi) lack of health care infrastructure and facilities; and

"(vii) lack of health care professional staffing and recruitment;

"(D) disparities in quality of care received, including discrimination in health care settings and the use of racially biased practice guidelines and algorithms; and

"(E) disparities in utilization of care.

"(2) Analysis of cross-sectional information.—The Director of the Office of Health Equity shall ensure that the data collection and reporting process under paragraph (1) allows for the analysis of cross-sectional information on people's identities.

"(c) Policies.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop, coordinate, and promote policies that enhance health equity, including by—

"(1) providing recommendations on—

"(A) cultural competence, implicit bias, and ethics training with respect to health care workers;

"(B) increasing diversity in the health care workforce; and

"(C) ensuring sufficient health care professionals and facilities; and

"(2) ensuring adequate public health funding at the local and State levels to address health disparities.

"(d) Consultation.—In carrying out subsection (a), the Director of the Office of Health Equity, in coordination with the Director of the Indian Health Service, shall consult with Indian Tribes and with urban Indian organizations on data collection, reporting, and implementation of policies.

"(e) Annual report.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop and publish an annual report on—

"(1) statistics collected by the Office;

"(2) proposed evidence-based solutions to mitigate health inequities; and

"(3) health care professional staffing levels and access to facilities.

"(f) Centralized electronic repository.—In carrying out subsection (a), the Director of the Office of Health Equity shall—

"(1) establish and maintain a centralized electronic repository to incorporate data collected across Federal departments and agencies on race, ethnicity, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length

of stay in the United States, age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status; and

"(2) make such data available for public use and analysis.

"(g) Privacy.—Notwithstanding any other Federal or State law, no Federal or State official or employee or other entity shall disclose, or use, for any law enforcement or immigration purpose, any personally identifiable information (including with respect to an individual's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status) that is collected or maintained pursuant to this section.".

(i) Office of Primary Health Care.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.), as amended by subsection (h), is further amended by adding at the end the following:

"SEC. 1713. Office of Primary Health Care.

"(a) In general.—There is established, in the Office of Health Equity established under section 1712, an Office of Primary Health Care, to be headed by a Director, to ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to increasing access to high-quality primary health care, particularly in underserved areas and for underserved populations.

"(b) National Goals.—Not later than July 1, 2027, the Director of the Office of Primary Health Care shall publish national goals—

"(1) to increase access to high-quality primary health care, particularly in underserved areas and for underserved populations; and

"(2) to address health disparities, including with respect to race, ethnicity, national origin (disaggregated by major ethnic group and Tribal affiliation), primary language use, English proficiency status, immigration status, length of stay in the United States, age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status.

"(c) Other responsibilities.—In carrying out subsections (a) and (b), the Director of the Office of Primary Health Care shall—

"(1) coordinate, in consultation with the Secretary, health professional education policies and goals to achieve the national goals published pursuant to subsection (b);

"(2) develop and maintain a system to monitor the number and specialties of individuals pursuing careers in, or practicing, primary health care through their health professional education, any postgraduate training, and professional practice;

"(3) develop, coordinate, and promote policies that expand the number of primary health care practitioners including primary medical, dental, and behavioral health care providers, registered nurses, and other advanced practice clinicians;

"(4) recommend appropriate workforce training, technical assistance, and patient protection enhancements for primary health care practitioners, including registered nurses, to achieve uniform high quality and patient safety;

"(5) provide recommendations on targeted programs and resources for Federally qualified health centers, community health centers, rural health centers, behavioral health clinics, and other community-based organizations;

"(6) provide recommendations for broader patient referral to additional resources, not limited to health care, and collaboration with other organizations and sectors that influence health outcomes; and

"(7) consult with the Secretary on the allocation of the special projects budget under section 326(a)(1)(B)(iii) of the POPULIST Act.

"(d) Rule of construction.—Nothing in this section shall be construed—

"(1) to preempt any provision of State law establishing practice standards or guidelines for health care professionals, including professional licensing or practice laws or regulations; or

"(2) to require that any State impose additional educational standards or guidelines for health care professionals.".

SEC. 327. MEDICARE FOR ALL TRUST FUND.

(a) In general.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Medicare for All Trust Fund (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) Appropriations into Trust Fund.—

(1) Taxes.—There are appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits are first available under section 321(f), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is attributable to the amendments made by section 328(b) and section 328(d)(4). The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) Current program receipts.—

(A) Initial year.—Notwithstanding any other provision of law, there is hereby appropriated to the Trust Fund for the 2028 fiscal year an amount equal to the aggregate amount appropriated for the preceding fiscal year for the following (increased by the consumer price index for all urban consumers for the fiscal year involved):

(i) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (other than amounts attributable to any premiums under such title).

(ii) The Medicaid program under State plans approved under title XIX of such Act (42 U.S.C. 1396 et seq.).

(iii) The Federal Employees Health Benefits program, under chapter 89 of title 5, United States Code.

(iv) The maternal and child health program (under title V of the Social Security Act (42 U.S.C. 701 et seq.)), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health care items and services the payment of which may be made under this subtitle.

(B) Subsequent years.—Notwithstanding any other provision of law, there is appropriated to the Trust Fund for each fiscal year following the fiscal year in which the appropriation is made under subparagraph (A), an amount equal to the amount appropriated to the Trust Fund for the previous year, adjusted for reductions in costs resulting from the implementation of this subtitle, changes in the consumer price index for all urban consumers for the fiscal year involved, and other factors determined appropriate by the Secretary.

(c) Incorporation of provisions.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act (42 U.S.C. 1395i) shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust Fund under such section 1817, except that, for purposes of applying such subsections to this section, the “Board of Trustees of the Trust Fund” or the “Board of Trustees” shall mean the “Secretary”.

(d) Transfer of funds.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) after the payment of claims for items and services furnished under title XVIII of such Act have been completed shall be transferred into the Medicare for All Trust Fund under this section.

(e) Medicare part B premium determination.—Section 1395r(a)(3) of title 42, United States Code, is amended by striking “(except as provided in subsection (g)) is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph

(1),” and inserting “shall be equal to 15 percent of the basic wage calculated pursuant to section 1398b(d) of this title (except that in the case of an enrollee who has not attained 19 years of age, the monthly premium rate shall be equal to 10 percent of the basic wage)”.

(f) Effective date.—The amendment made by subsection (e) shall apply beginning with the first month that begins after the month in which American Union Job payments are first issued.

SEC. 328. DEFINITIONS AND CROSS-REFERENCES.

(a) Definitions.—In this subtitle—

(1) Secretary.—The term “Secretary” means the Secretary of Health and Human Services;

(2) State.—The term “State” means any of the 50 States, the District of Columbia, or a territory of the United States; and

(3) United States.—The term “United States” shall include the 50 States, the District of Columbia, and the territories of the United States.

(b) Prohibition of employee benefits duplicative of benefits under the Medicare for All Program; coordination in case of workers’ compensation.—

(1) In general.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

“SEC. 524. Prohibition of employee benefits duplicative of Medicare for All Program benefits; coordination in case of workers’ compensation.

“(a) In general.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Program established under section 321 of the POPULIST Act (referred to in this section as the ‘Medicare for All Program’).

“(b) Reimbursement.—Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the Medicare for All Program for the cost of such services.

“(c) Definitions.—In this subsection—

“(1) Workers compensation carrier.—The term ‘workers compensation carrier’ means an insurance company that underwrites workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits;

“(2) Workers compensation medical benefits.—The term ‘workers compensation medical benefits’ means, with respect to an enrollee who is an employee subject to the workers

compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee; and

"(3) Workers compensation services.—The term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation items and services and long-term care items and services) commonly used for treatment of work-related injuries and illnesses.".

(2) Conforming amendment.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the following: "Paragraph (3) shall apply subject to section 524(b) (relating to reimbursement of the Medicare for All Program by workers compensation carriers).".

(3) Clerical amendment.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 523 the following new item:

"Sec. 524. Prohibition of employee benefits duplicative of Medicare for All Program benefits; coordination in case of workers' compensation.".

(c) Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.—

(1) In general.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(2) Conforming amendments.—

(A) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(i) by striking paragraph (7); and

(ii) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(B) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking "paragraph (1) or (4) of section 606,".

(C) Section 502(e) of such Act (29 U.S.C. 1132(e)) is amended by striking "paragraphs (1)(B) and (7)" and inserting "paragraph (1)(B)".

(D) Section 502(l)(3)(B) of such Act (29 U.S.C. 1132(l)(3)(B)) is amended by striking "subsection (a)(9)" and inserting "subsection (a)(8)".

(E) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(i) in paragraph (7), by striking "section 206(d)(3)(B)(i)),"; and

(ii) by striking paragraph (8).

(F) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

(d) Relationship to existing Federal health programs.—

(1) Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP).—

(A) In general.—Notwithstanding any other provision of law, subject to subparagraphs (B) and (C)—

(i) no benefits shall be available under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for any item or service furnished beginning January 1, 2029;

(ii) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act (42 U.S.C. 1396 et seq.) for any item or service furnished on or after such date;

(iii) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act (42 U.S.C. 1397aa et seq.) for any item or service furnished on or after such date; and

(iv) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act (42 U.S.C. 1396b(a); 42 U.S.C. 1397ee) with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(B) Transition.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2029, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI of such Act, the Secretary shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(C) Continued coverage of long-term care and other certain services under Medicaid.—

(i) In general.—This paragraph shall not apply to entitlement to medical assistance provided under title XIX of the Social Security Act for—

(I) institutional long-term care services (as defined in section 1949(b) of such Act); or

(II) any other service for which benefits are not available under the Medicare for All Program and which is furnished under a State plan under title XIX of the Social Security Act which provided for medical assistance for such service on January 1, 2025.

(ii) Coordination between Secretary and States.—The Secretary shall coordinate with the directors of State agencies responsible for administering State plans under title XIX of the Social Security Act to—

(I) identify items and services described in clause (i)(II) with respect to each State plan; and

(II) ensure that such items and services continue to be made available under such plan.

(iii) State maintenance of effort requirement.—With respect to any service described in clause (i)(II) that is made available under a State plan under title XIX of the Social Security Act, the maintenance of effort requirements described in section 1949(c) of such Act shall apply to such service in the same manner that such requirements apply to institutional long-term care services.

(2) Federal employees health benefits program.—No benefits shall be made available under chapter 89 of title 5, United States Code, with respect to items and services furnished to any individual eligible to enroll under the Medicare for All Program.

(3) Treatment of benefits for veterans and Native Americans.—

(A) In general.—Nothing in this subtitle shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, the eligibility of individuals for TRICARE medical benefits and services provided under sections 1079 and 1086 of title 10, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

(B) Reevaluation.—No reevaluation of the Indian Health Service shall be undertaken without consultation with Tribal leaders and stakeholders.

(4) Sunset of provisions related to the Federal and State Exchanges.—The Federal and State Exchanges established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

(e) Effective date.—The provisions of and amendments made by this section shall take effect January 1, 2029.

SEC. 329. MEDICARE FOR ALL TRANSITION.

(a) Expanding Medicare to cover dental and vision services and hearing aids and examinations under part B.—

(1) Coverage.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (II), by striking “and” at the end; and

(B) by adding at the end the following new subparagraphs:

“(KK) dental services; and

“(LL) vision services;”.

(2) Payment.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and” before “(HH)”; and

(B) by inserting before the semicolon at the end the following: “, (II) with respect to dental services described in section 1861(s)(2)(KK), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b), and (JJ) with respect to vision services described in section 1861(s)(2)(LL), the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b)”.

(3) Conforming amendments.—

(A) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by striking “hearing aids or examinations therefor,”.

(B) Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by striking paragraph (12).

(b) Eliminating the 24-month waiting period for Medicare coverage for individuals with disabilities.—

(1) In general.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(A) in paragraph (2)(A), by striking “, and has for 24 calendar months been entitled to,”;

(B) in paragraph (2)(B), by striking “, and has been for not less than 24 months,”;

(C) in paragraph (2)(C)(ii), by striking “, including the requirement that he has been entitled to the specified benefits for 24 months,”;

(D) in the first sentence, by striking “for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and” and inserting “for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and”; and

(E) in the second sentence, by striking "the 'twenty-fifth month of his entitlement'" and all that follows through "paragraph (2)(C) and".

(2) Conforming amendments.—

(A) Section 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended—

(i) by striking subsections (e)(1)(B), (f), and (h); and

(ii) by redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(B) Medicare description.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking "have been entitled for not less than 24 months" and inserting "are entitled".

(C) Medicare coverage.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking "25th month of" and inserting "month following the first month of".

(D) Railroad retirement system.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(i) by striking "has been entitled to an annuity" and inserting "is entitled to an annuity";

(ii) by striking ", for not less than 24 months"; and

(iii) by striking "could have been entitled for 24 calendar months, and".

(3) Effective date.—The amendments made by this subsection shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1, 2026, and before January 1, 2029.

(c) Medicare fee-for-service beneficiary protections and Medigap reforms.—

(1) Protecting Medicare fee-for-service beneficiaries from high out-of-pocket costs.—

(A) Protection against high out-of-pocket expenditures.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"Sec. 1899E. Protection Against High Out-of-Pocket Expenditures

"(a) In general.—Notwithstanding any other provision of this title, in the case of an individual entitled to, or enrolled for, benefits under part A or enrolled in part B, if the amount of the out-of-pocket cost-sharing of such individual for a year (effective beginning January 1, 2027)

equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing that occurred during that year.

"(b) Out-of-pocket cost-sharing defined.—

"(1) In general.—Subject to paragraphs (2) and (3), in this section, the term 'out-of-pocket cost-sharing' means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to—

"(A) coinsurance and copayments applicable under part A or B; or

"(B) for items and services that would have otherwise been covered under part A or B but for the exhaustion of those benefits.

"(2) Certain costs not included.—

"(A) Non-covered items and services.—Expenses incurred for items and services which are not included (or treated as being included) under part A or B shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

"(B) Items and services not furnished on an assignment-related basis.—If an item or service is furnished to an individual under this title and is not furnished on an assignment-related basis, any additional expenses the individual incurs above the amount the individual would have incurred if the item or service was furnished on an assignment-related basis shall not be considered incurred expenses for purposes of determining out-of-pocket cost-sharing under paragraph (1).

"(3) Source of payment.—For purposes of paragraph (1), the Secretary shall consider expenses to be incurred by the individual without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such expenses.".

(B) Elimination of parts A and B deductibles.—

(i) Part A.—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended by adding at the end the following new paragraph:

"(4) For each year (beginning January 1, 2029), the inpatient hospital deductible for the year shall be $0.".

(ii) Part B.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended, in the first sentence—

(I) by striking "and for a subsequent year" and inserting "for each of 2006 through 2028"; and

(II) by inserting ", and $0 for each subsequent year" after "$1)".

(2) Reducing Medicare part D annual out-of-pocket threshold.—Section 1860D–2(b)(4)(B)(i) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(B)(i)) is amended—

(A) in subclause (VIII), by striking “or”;

(B) in subclause (VIII)—

(i) by striking "a subsequent year" and inserting "2026"; and

(ii) by striking the period at the end and inserting "; or"; and

(C) by adding at the end the following new subclause:

“(IX) for 2027 and 2028, $1,200; provided that the Secretary may exempt costs incurred for a covered part D drug that is an applicable drug under section 1860D–14A(g)(2) if the Secretary determines that a generic version of that drug is available.”.

(3) Guaranteed issue of Medigap policies.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(aa) Guaranteed issue for all Medigap-eligible Medicare beneficiaries.—Notwithstanding paragraphs (2)(A) and (2)(D) of subsection (s) or any other provision of this section, on or after the date of enactment of this subsection, the issuer of a Medicare supplemental policy may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition in the case of any individual entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B.”.

(d) Establishment of the Medicare transition plan.—

(1) In general.—To carry out the purpose of this subsection, for plan years beginning with the first plan year that begins after July 4, 2026 and ending January 1, 2029, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this subsection as the “Administrator”), shall establish, and provide for the offering through the Exchanges, of a public health plan (in this subtitle referred to as the “Medicare Transition plan”) that provides affordable, high-quality health benefits coverage throughout the United States.

(2) Administrating the Medicare transition.—

(A) Administrator.—The Administrator shall administer the Medicare Transition plan in accordance with this subsection.

(B) Application of ACA requirements.—Consistent with this subsection, the Medicare Transition plan shall comply with requirements under title I of the Patient Protection and Affordable Care Act (and the amendments made by that title) and title XXVII of the

Public Health Service Act (42 U.S.C. 300gg et seq.) that are applicable to qualified health plans offered through the Exchanges, subject to the limitation under paragraph (5)(B).

(C) Offering through Exchanges.—The Medicare Transition plan shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)(2))) who wish to make such plan available to their employees.

(D) Eligibility to purchase.—Any United States resident may enroll in the Medicare Transition plan.

(3) Benefits; actuarial value.—In carrying out this subsection, the Administrator shall ensure that the Medicare Transition plan provides—

(A) coverage for the benefits required to be covered under section 322; and

(B) coverage of benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(4) Providers and reimbursement rates.—

(A) In general.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 322(a), provided under the Medicare Transition plan, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.). For items and services covered under the Medicare Transition plan but not covered under such parts A and B, the Administrator shall reimburse providers at rates set by the Administrator in a manner consistent with the manner in which rates for other items and services were set under the original Medicare fee-for-service program.

(B) Prescription drugs.—Any payment rate under this paragraph for a prescription drug shall be at a rate negotiated by the Administrator with the manufacturer of the drug. If the Administrator is unable to reach a negotiated agreement on such a reimbursement rate, the Administrator shall establish the rate at an amount equal to the lesser of—

(i) the price paid by the Secretary of Veterans Affairs to procure the drug under the laws administered by the Secretary of Veterans Affairs;

(ii) the price paid to procure the drug under section 8126 of title 38, United States Code; or

(iii) the best price determined under section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

(C) Participating providers.—

(i) In general.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this subtitle shall be a participating provider in the Medicare Transition plan.

(ii) Additional providers.—The Administrator shall establish a process to allow health care providers not described in clause (i) to become participating providers in the Medicare Transition plan. Such process shall be similar to the process applied to new providers under the Medicare program.

(5) Premiums.—

(A) Determination.—The Administrator shall determine the premium amount for enrolling in the Medicare Transition plan, which—

(i) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section 2701(a)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)); and

(ii) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by paragraph (7).

(B) Limitation.—Variation in premium rates of the Medicare Transition plan by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

(6) Termination.—The provisions of this subsection shall cease to have force or effect on the date on which benefits are first available under section 321(f).

(7) Tax credits and cost-sharing subsidies.—

(A) Premium assistance tax credits.—

(i) Credits allowed to Medicare Transition plan enrollees at or above 44 percent of poverty in non-expansion States.—Section 36B(c)(1) of the Internal Revenue Code of 1986 is amended by inserting after subparagraph (A) the following new subparagraph:

“(B) Special rules for Medicare Transition plan enrollees.—

“(i) In general.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 329(d) of the POPULIST Act for all months in the taxable year, subparagraph (A) shall be applied without regard to ‘but does not exceed 400

percent'. The preceding sentence shall not apply to any taxable year to which subparagraph (D) applies.

"(ii) Enrollees in Medicaid non-expansion States.—In the case of a taxpayer residing in a State which (as July 4, 2026) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 329(d) of the POPULIST Act for all months in the taxable year, subparagraph (A) shall be applied by substituting '0 percent' for '100 percent' each place it appears.".

(ii) Premium assistance amounts for taxpayers enrolled in Medicare Transition plan.—

(I) In general.—Section 36B(b)(3)(A) of such Code is amended—

(aa) by redesignating clauses (ii) and (iii) as clauses (iii) and (iv), respectively;

(bb) by striking "clause (ii)" in clause (i) and inserting "clauses (ii) and (iii)"; and

(cc) by inserting after clause (i) the following new clause:

"(ii) Special rules for taxpayers enrolled in Medicare Transition plan.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition plan established under section 329(d) of the POPULIST Act for all months in the taxable year the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

"In the case of household income (expressed as a percent of poverty line) within the following income tier: The initial premium percentage is— The final premium percentage is—

"Up to 100 percent	2	2
"100 percent up to 138 percent	2.04	2.04
"138 percent up to 150 percent	3.06	4.08
"150 percent and above	4.08	5.

"The preceding sentence shall not apply to any taxable year to which clause (iv) applies.".

(II) Conforming amendments.—

(aa) Subclause (I) of clause (iii) of section 36B(b)(3)(A) of such Code, as redesignated by subclause (I)(aa), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(bb) Section 36B(b)(3)(A)(iv)(I) of such Code, as redesignated by subclause (I)(aa), is amended by striking "clause (ii)" and inserting "clause (iii)".

(B) Cost-sharing subsidies.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(i) by inserting ", or in the Medicare Transition plan established under section 329(d) of the POPULIST Act," after "coverage" in paragraph (1);

(ii) by redesignating paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(iii) by striking "insured.—In this section" and inserting "insured.—

"(1) In general.—In this section";

(iv) by striking the flush language; and

(v) by adding at the end the following new paragraph:

"(2) Special rules.—

"(A) Medicare Transition plan enrollees in Medicaid non-expansion States.—In the case of an individual residing in a State which, as of July 4, 2026, does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition plan, subparagraph (A), paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.

"(C) Adjusted cost-sharing for Medicare Transition plan enrollees.—In the case of any individual who enrolls in such Medicare Transition plan, in lieu of the percentages under subsection (c)(1)(B)(i) and (c)(2), the Secretary shall prescribe a method of determining the cost-sharing reduction for any such individual such that the total of the cost-sharing and the premiums paid by the individual under such Medicare Transition plan does not exceed the percentage of the total allowed costs of benefits provided under the plan equal to the final premium percentage applicable to such individual under section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986.".

(8) Conforming amendments.—

(A) Treatment as a qualified health plan.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(2)) is amended—

(i) in the paragraph heading, by inserting ", the Medicare Transition plan," before "and"; and

(ii) by inserting "the Medicare Transition plan under section 329(d) of the POPULIST Act," before "and a multi-State plan".

(B) Level playing field.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting "the Medicare Transition plan under section 329(d) of the POPULIST Act," before "or a multi-State qualified health plan".

(e) Lowering the Medicare age.—

(1) In general.—Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), as amended by subsection (c)(1), is amended by adding at the end the following new section:

"Sec. 1899F. Temporary Medicare Buy-In Option for Certain Individuals

"(a) No effect on other benefits for individuals otherwise eligible or on Trust Funds.—The Secretary shall implement the provisions of this section in such a manner to ensure that such provisions—

"(1) have no effect on the benefits under this title for individuals who are entitled to, or enrolled for, such benefits other than through this section; and

"(2) have no negative impact on the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund).

"(b) Option.—

"(1) In general.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll under this section.

"(2) Part A, B, and D benefits.—An individual enrolled under this section is entitled to the same benefits (and shall receive the same protections) under this title as an individual who is entitled to benefits under part A and enrolled under parts B and D, including the ability to enroll in a private plan that provides qualified prescription drug coverage.

"(3) Requirements for eligibility.—The requirements described in this paragraph are the following:

"(A) The individual is a resident of the United States.

"(B) The individual is—

"(i) a citizen or national of the United States; or

"(ii) an alien lawfully admitted for permanent residence.

"(C) The individual is not otherwise entitled to benefits under part A or eligible to enroll under part A or part B.

"(D) The individual has attained the applicable years of age but has not attained 65 years of age.

"(4) Applicable years of age defined.—For purposes of this section, the term 'applicable years of age' means—

"(A) effective January 1, 2027, the age of 52; and

"(B) effective January 1, 2028, the age of 40.

"(c) Enrollment; coverage.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

"(d) Premium.—

"(1) Amount of monthly premiums.—The Secretary shall, during September of each year (beginning in September 2026), determine a monthly premium for all individuals enrolled under this section. Such monthly premium shall be equal to 1/12 of the annual premium computed under paragraph (2)(B), which shall apply with respect to coverage provided under this section for any month in the succeeding year.

"(2) Annual premium.—

"(A) Combined per capita average for all Medicare benefits.—The Secretary shall estimate the average, annual per capita amount for benefits and administrative expenses that will be payable under parts A, B, and D in the year for all individuals enrolled under this section.

"(B) Annual premium.—The annual premium under this subsection for months in a year is equal to the average, annual per capita amount estimated under subparagraph (A) for the year.

"(3) Increased premium for complementary plans.—Nothing in this section shall preclude an individual from choosing a prescription drug plan or other complementary plans which requires the individual to pay an additional amount (because of supplemental benefits or because it is a more expensive plan). In such case the individual would be responsible for the increased monthly premium.

"(e) Payment of premiums.—

"(1) In general.—Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary determines appropriate.

"(2) Deposit.—Amounts collected by the Secretary under this section shall be deposited in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account within such Trust Fund) in such proportion as the Secretary determines appropriate.

"(f) Not eligible for Medicare cost-sharing assistance.—An individual enrolled under this section shall not be treated as enrolled under any part of this title for purposes of obtaining medical assistance for Medicare cost-sharing or otherwise under title XIX.

"(g) Treatment in relation to the Affordable Care Act.—

"(1) Satisfaction of individual mandate.—For purposes of applying section 5000A of the Internal Revenue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

"(2) Eligibility for premium assistance.—Coverage provided under this section—

"(A) shall be treated as coverage under a qualified health plan in the individual market enrolled in through the Exchange where the individual resides for all purposes of section 36B of the Internal Revenue Code of 1986 other than subsection (c)(2)(B) thereof; and

"(B) shall not be treated as eligibility for other minimum essential coverage for purposes of subsection (c)(2)(B) of such section 36B.

"The Secretary shall determine the applicable second lowest cost silver plan which shall apply to coverage under this section for purposes of section 36B of such Code.

"(3) Eligibility for cost-sharing subsidies.—For purposes of applying section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071)—

"(A) coverage provided under this section shall be treated as coverage under a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

"(B) the Secretary shall be treated as the issuer of such plan.

"(h) Consultation.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing beneficiaries, health care providers, employers, and insurance companies.".

(f) Patient protections during Medicare for All transition period.—

(1) Definitions.—In this subsection, the terms "health insurance coverage", "health insurance issuer", and "group health plan" have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(2) Minimizing disruptions to patient care.—The Secretary shall ensure that all individuals enrolled in, or who seek to enroll in, a group health plan, health insurance coverage offered by a health insurance issuer, or the plan established under section 329(d) during the transition period of this subtitle are protected from disruptions in their care during the transition period.

(3) Public consultation.—The Secretary shall consult with communities and advocacy organizations of individuals living with disabilities and other patient advocacy organizations to ensure the transition described in paragraph (2) takes into account the safety and continuity of care for individuals with disabilities, complex medical needs, or chronic conditions.

(g) Clerical amendment.—The table of contents in part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end the following new sections:

"Sec. 1395ooo. Protection Against High Out-of-Pocket Expenditures.

"Sec. 1395ppp. Temporary Medicare Buy-In Option for Certain Individuals.".

Subtitle C—Addressing Drug Prices

SEC. 331. ACCELERATION OF PHARMACY BENEFIT MANAGER ACCOUNTABILITY REQUIREMENTS.

(a) Acceleration of effective date for Medicare Part D and MA-PD plans.—Section 1860D-12(h) of the Social Security Act (42 U.S.C. 1395w-112(h)), is amended—

(1) in the matter preceding paragraph (1), by striking "For plan years beginning on or after January 1, 2028" and inserting "For plan years beginning on or after January 1, 2027"; and

(2) in paragraph (5)(A), by striking "June 1, 2027" and inserting "December 1, 2026".

(b) Conforming amendment for Medicare Advantage prescription drug plans.—Section 1857(f)(3)(G) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)(G)) is amended by striking "January 1, 2028" and inserting "January 1, 2027".

SEC. 332. PROHIBITING PAY-FOR-DELAY AGREEMENTS.

(a) Amendment to definitions.—Section 1111 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by adding at the end the following:

"(9) REVERSE PAYMENT AGREEMENT.—

"(A) In general.—The term 'reverse payment agreement' means any agreement, settlement, or understanding, whether oral or written, in which a brand name drug

company provides anything of value to a generic drug applicant in exchange for non-competition with respect to a generic drug.

"(B) Exception.—The term 'reverse payment agreement' does not include compensation that is strictly limited to—

"(i) reimbursement of documented and reasonable litigation costs actually incurred by the generic drug applicant in connection with patent litigation; or

"(ii) payment for bona fide services provided by the generic drug applicant, if such payment reflects fair market value and is not conditioned on, linked to, or accompanied by non-competition.

"(10) ANYTHING OF VALUE.—The term 'anything of value' includes money, forgiveness of debt, exclusive licenses, supply agreements, distribution agreements, side deals, promises not to market a generic drug, or any other form of consideration, whether direct or indirect.

"(11) NON-COMPETITION.—The term 'non-competition' means delayed market entry, abandonment or withdrawal of a patent challenge, agreement not to market a generic drug, or any restriction that has the effect of limiting or delaying competition with a brand name drug."

(b) Prohibition.—The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is amended by inserting after section 1114 the following:

"SEC. 1114A. PROHIBITION ON REVERSE PAYMENT AGREEMENTS.

"(a) In general.—It is unlawful for a brand name drug company and a generic drug applicant to enter into a reverse payment agreement.

"(b) Enforcement.—A violation of this section shall be treated as a violation of a rule defining an unfair, deceptive, or abusive act or practice under the Federal Trade Commission Act (15 U.S.C. 41 et seq.), and all powers and authorities of the Commission under that Act shall be available to enforce this section as if this section were incorporated into and made a part of that Act."

(c) Enforcement amendments.—Section 1115 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is amended—

(1) in subsection (a), by striking "$11,000" and inserting "$25,000"; and

(2) by adding at the end the following:

"(c) Additional remedies.—

"(1) Disgorgement.—In addition to any other remedy available under this subtitle, the Commission or the Assistant Attorney General may seek disgorgement of any consideration exchanged in violation of section 1114A.

"(2) Monetary penalty in lieu of disgorgement.—In the alternative to disgorgement under paragraph (1), the Commission or the Assistant Attorney General may seek an additional civil penalty in an amount equal to the monetary value of any consideration exchanged in violation of section 1114A.".

SEC. 333. CODIFYING THE ANTI-KICKBACK RULE

(a) Incorporation of specified regulations.—The provisions of the final rule promulgated by the Health and Human Services Department, entitled "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees", as published in the Federal Register on November 30, 2020 (85 Fed. Reg. 76666), are incorporated into this Act and shall be treated as though such provisions are set forth in this subsection.

(b) Effect of incorporation.—The regulations incorporated under subsection (a) may be altered only by means of an Act of Congress. To the extent that any provision of such regulations does not conform with this Act, the provisions of this Act shall govern.

(c) Definition of regulation.—In this section, the term "regulation" means any rule, regulation, guideline, interpretation, order, or requirement of general applicability prescribed by any officer or employee of the executive branch.

SEC. 334. REDUCTION IN MEDICARE PART B PAYMENT PERCENTAGE FOR AVERAGE SALES PRICE DRUGS.

(a) In general.—Section 1847A(b)(1) of the Social Security Act (42 U.S.C. 1395w–3a(b)(1)) is amended by striking “106 percent” each place it appears and inserting “94 percent”.

(b) Effective date.—The amendment made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2027.

SEC. 335. DRUG PRICES, PHARMACY BENEFIT MANAGERS, AND COMPETITION.

(a) Increasing transparency in generic drug applications.—

(1) In general.—Section 505(j)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(3)) is amended by adding at the end the following:

"(H) (i) Upon request (in controlled correspondence or an analogous process) by a person that has submitted or intends to submit an abbreviated application under this subsection for a drug that is required by regulation to contain one or more of the same inactive ingredients in the same concentrations as the listed drug referred to, or for which the Secretary determines there is a scientific justification for an approach that is in vitro in whole or in part to be used to demonstrate bioequivalence for a drug if such a drug contains one or more of the same inactive ingredients in the same concentrations as the listed drug, the Secretary shall inform the person whether such drug is qualitatively and quantitatively the same as the listed drug. The Secretary

may also provide such information to such a person on the Secretary's own initiative during the review of an abbreviated application under this subsection for such drug.

"(ii) Notwithstanding section 301(j), if the Secretary determines that such drug is not qualitatively or quantitatively the same as the listed drug, the Secretary shall identify and disclose to the person—

"(I) the ingredient or ingredients that cause such drug not to be qualitatively or quantitatively the same as the listed drug; and

"(II) for any ingredient for which there is an identified quantitative deviation, the amount of such deviation.

"(iii) If the Secretary determines that such drug is qualitatively and quantitatively the same as the listed drug, the Secretary shall not change or rescind such determination after the submission of an abbreviated application for such drug under this subsection unless—

"(I) the formulation of the listed drug has been changed and the Secretary has determined that the prior listed drug formulation was withdrawn for reasons of safety or effectiveness; or

"(II) the Secretary makes a written determination that the prior determination must be changed because an error has been identified.

"(iv) If the Secretary makes a written determination described in clause (iii)(II), the Secretary shall provide notice and a copy of the written determination to the person making the request under clause (i).

"(v) The disclosures required by this subparagraph are disclosures authorized by law, including for purposes of section 1905 of title 18, United States Code.".

(2) Guidance.—

(A) In general.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue draft guidance, or update guidance, describing how the Secretary will determine whether a drug is qualitatively and quantitatively the same as the listed drug (as such terms are used in section 505(j)(3)(H) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1)), including with respect to assessing pH adjusters.

(B) Process.—In issuing guidance under this paragraph, the Secretary of Health and Human Services shall—

(i) publish draft guidance;

(ii) provide a period of at least 60 days for comment on the draft guidance; and

(iii) after considering any comments received and not later than one year after the close of the comment period on the draft guidance, publish final guidance.

(3) Applicability.—Section 505(j)(3)(H) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), applies beginning on the date of enactment of this Act, irrespective of the date on which the guidance required by paragraph (2) is finalized.

(b) Improving transparency and preventing the use of abusive spread pricing and related practices in Medicaid.—

(1) Spread pricing.—

(A) In general.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended by adding at the end the following:

"(6) Pharmacy price reimbursement required.—

"(A) In general.—A contract between the State and a pharmacy benefit manager (in this paragraph referred to as a 'PBM'), or a contract between the State and a designated entity (as defined in subparagraph (C)) that includes provisions making the designated entity responsible for the administration of medical assistance consisting of covered outpatient drugs for individuals enrolled with the designated entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or designated entity, is based on a pharmacy price reimbursement model under which—

"(i) any payment made by the designated entity or the PBM (as applicable) for such a drug—

"(I) is limited to—

"(aa) ingredient cost; and

"(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State plan or waiver would pay if the plan or waiver was making the payment directly;

"(II) is passed through in its entirety by the designated entity or PBM to the pharmacy or provider that dispenses the drug and is not retroactively denied or reduced except as permitted or required under Federal or State law or regulation; and

"(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the designated entity or the PBM, except that any payment by the designated entity or the PBM for the ingredient cost of such a drug purchased by a covered entity (as defined in subsection (a)(5)(B)) may exceed the actual acquisition cost (as defined in

section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)) for such drug if—

"(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act (42 U.S.C. 256b);

"(bb) such payment for such cost of such drug does not exceed the maximum payment that would have been made by the designated entity or the PBM for the ingredient cost of such drug had such drug not been purchased by such a covered entity; and

"(cc) such covered entity reports to the Secretary, on an annual basis (in a form and manner specified by the Secretary) and with respect to payments for such costs of such drugs so purchased by such covered entity that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess;

"(ii) payment to the designated entity or the PBM (as applicable) for administrative services performed by the designated entity or PBM is limited to an administrative fee that reflects the fair market value of providing such services;

"(iii) the designated entity or the PBM (as applicable) makes available to the State, and the Secretary upon request, all costs and payments related to covered outpatient drugs and accompanying administrative services incurred, received, or made by the designated entity or the PBM, including ingredient costs, professional dispensing fees, administrative fees, post-sale and post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees, and any and all other remuneration; and

"(iv) any form of spread pricing whereby any amount charged or claimed by the designated entity or the PBM (as applicable) is in excess of the amount paid to the pharmacies by the designated entity or the PBM, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments (after allowing for a fair market administrative fee as described in clause (ii)), is not allowable for purposes of claiming Federal matching payments under this title.

"(B) Making certain information available.—The Secretary shall publish, not less frequently than on an annual basis, information received by the Secretary pursuant to subparagraph (A)(i)(III)(cc). Such information shall be so published in an electronic and searchable format, such as through the 340B Office of Pharmacy Affairs Information System (or a successor system).

"(C) Definitions.—In this paragraph:

"(i) Designated entity.—The term 'designated entity' means a managed care entity or other specified entity.

"(ii) Managed care entity; other specified entity.—The terms 'managed care entity' and 'other specified entity' have the meaning given such terms in section 1903(m)(9)(D).".

(B) Conforming amendments.—Section 1903(m) of such Act (42 U.S.C. 1396b(m)) is amended—

(i) in paragraph (2)(A)(xiii)—

(I) by striking "and (III)" and inserting "(III)";

(II) by inserting before the period at the end the following: ", and (IV) with respect to covered outpatient drugs and related administrative services (as applicable) provided by the entity (or by a pharmacy benefit manager on behalf of the entity under a contract or other arrangement with the entity), that payment for such drugs and related administrative services is based on a pharmacy price reimbursement model described in section 1927(e)(6)(A)"; and

(III) by moving the margin 2 ems to the left; and

(ii) by adding at the end the following new paragraph:

"(10) No payment shall be made under this title to a State with respect to expenditures incurred by it for payment for services provided by an other specified entity (as defined in paragraph (9)(D)) unless the contract between the State and the entity for the provision of such services provides, with respect to covered outpatient drugs and related administrative services (as applicable) provided by the entity (or by a pharmacy benefit manager on behalf of the entity under a contract or other arrangement with the entity), that payment for such drugs and related administrative services is based on a pharmacy price reimbursement model described in section 1927(e)(6)(A).".

(C) Effective date.—The amendments made by this paragraph shall take effect on January 1, 2027, and shall apply to contracts, arrangements, items, and services furnished on or after that date, without regard to the effective date of any contract.

SEC. 336. PHARMACY PAYMENT AND REIMBURSEMENT.

(a) Definitions.—In this section:

(1) Affiliate.—The term “affiliate” means an entity, including a pharmacy, that directly or indirectly through one or more intermediaries—

(A) owns, controls, or has an investment interest in a pharmacy benefits manager;

(B) is owned, controlled by, or has an investment interest holder who is a pharmacy benefits manager; or

(C) is under common ownership or corporate control of a pharmacy benefits manager.

(2) Beneficiary.—The term “beneficiary” means a person who receives prescription drug benefits pursuant to a Federal health care program.

(3) Bona fide service fee.—The term "bona fide service fee" has the meaning given that term in section 1860D–12(h)(7)(B) of the Social Security Act (42 U.S.C. 1395w–112(h)(7)(B)).

(4) Cost sharing requirement.—The term “cost sharing requirement” means any coinsurance or deductible imposed on a beneficiary for a prescription drug furnished under a Federal health care program.

(5) Federal health care program.—The term "Federal health care program" means—

(A) a prescription drug plan under part D of title XVIII of the Social Security Act;

(B) an MA–PD plan under part C of such title;

(C) a managed care entity (as defined in section 1932(a)(1)(B) of such Act (42 U.S.C. 1396u–2(a)(1)(B));

(D) an other specified entity (as defined in section 1903(m)(9)(D)(iii) of the Social Security Act (42 U.S.C. 1396b(m)(9)(D)(iii));

(E) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code; or

(F) the TRICARE program (as defined in section 1072 of title 10, United States Code).

(6) In-network pharmacy.—The term “in-network pharmacy” means a pharmacy that is licensed by the State board of pharmacy in the State in which such pharmacy is located, that fills or seeks to fill a prescription for a prescription drug for a beneficiary, and is not an excluded entity and does not have an owner or employee who is on a list of excluded individuals or entities maintained by the Office of Inspector General pursuant to section 1128 of the Social Security Act (42 U.S.C. 1320a–7).

(7) Pharmacy benefits management services.—The term “pharmacy benefits management services”—

(A) means the managing or administration of a plan or program that pays for, reimburses, and covers the cost of prescription drugs and medical devices; and

(B) includes the processing and payment of claims for prescription drugs and the adjudication of appeals or grievances related to the prescription drug benefit.

(8) Pharmacy benefits manager.—The term “pharmacy benefits manager” means a person, business entity, affiliate, or other entity that performs pharmacy benefits management services.

(9) Prescription drug.—The term “prescription drug” means a prescription drug covered by a Federal health care program that is dispensed to a beneficiary for self-administration.

(10) Rebate.—The term “rebate” means any payments and concessions that accrue to a pharmacy benefits manager or the plan sponsor client of such pharmacy benefits manager, directly or indirectly, including through an affiliate, subsidiary, third party, or intermediary, including an off-shore entity or group purchasing organization, from a pharmaceutical manufacturer, its affiliate, subsidiary, third party, or intermediary, including payments, discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered by such pharmacy benefits manager on behalf of a Federal health care program.

(11) Spread pricing.—The term “spread pricing” means the practice of a pharmacy benefits manager charging a Federal health care program more for a prescription drug than the amount such pharmacy benefits manager pays a pharmacy for a drug, including any post-sale or post-adjudication fees, discounts, or adjustments, provided that nothing herein shall be construed to allow post-sale or post-adjudication fees, discounts, or adjustments where otherwise prohibited by law.

(12) Steering.—The term “steering” means—

(A) directing, ordering, or requiring a beneficiary to use a specific pharmacy or pharmacies, including an affiliate pharmacy, for the purpose of filling a prescription or receiving services or other care from a pharmacist;

(B) offering or implementing health insurance plan designs that require a beneficiary to utilize a pharmacy or pharmacies, including an affiliate pharmacy, or that increases costs to a Federal health care program or a beneficiary, including requiring a beneficiary to pay the full cost for a prescription drug when such beneficiary chooses not to use a pharmacy benefits manager affiliate pharmacy;

(C) advertising, marketing, or promoting a pharmacy, including an affiliate pharmacy, over another in-network pharmacy;

(D) creating any network or engaging in any practice, including accreditation or credentialing standards, day supply limitations, or delivery method limitations, that exclude an in-network pharmacy or restrict an in-network pharmacy from filling a prescription for a prescription drug; or

(E) directly or indirectly engaging in any practice that attempts to influence or induce a pharmaceutical manufacturer to limit the distribution of a prescription drug to a small number of pharmacies or certain types of pharmacies, or to restrict distribution of such drug to non-affiliate pharmacies.

(b) In general.—A pharmacy benefits manager administering prescription drug benefits on behalf of a Federal health care program, either directly or through an affiliate of such pharmacy benefits manager, shall, on behalf of such program—

(1) reimburse an in-network pharmacy for the ingredient cost of a prescription drug in an amount equal to the sum of—

(A) the national average drug acquisition cost for the drug on the day of claim adjudication (or, in the case of a drug that does not appear on the national average drug acquisition cost index, the wholesale acquisition cost for such prescription drug); and

(B) an amount equal to 2 percent of the amount described in subparagraph (A), or $25, whichever is less;

(2) pay an in-network pharmacy a professional dispensing fee that is equal to the professional dispensing fee paid by the State in which the pharmacy is located under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for dispensing a prescription drug; and

(3) (A) subject to subparagraph (B), calculate a beneficiary's cost sharing requirement for a prescription drug at the point of sale based on a price that is reduced by an amount equal to at least 80 percent of all rebates received in connection with the dispensing of the prescription drug; or

(B) in the case of a prescription drug for which the rebate cannot be determined at the point of sale, calculate a beneficiary's cost sharing requirement for a prescription drug at the point of sale based on a price that is reduced by an amount equal to 80 percent of the lesser of the average aggregate rebate for such drug in the previous calendar year, or the highest possible rebate that can be received for such drug.

(c) Prohibited actions.—A pharmacy benefits manager administering prescription drug benefits under a Federal health care program shall not—

(1) engage in steering;

(2) engage in any practice that restricts a beneficiary from using any in-network pharmacy to fill a prescription drug;

(3) charge a beneficiary more for a prescription drug than the amount of reimbursement made to the pharmacy that dispenses such drug;

(4) require a beneficiary to obtain a brand name prescription drug when a lower cost, AB-rated generic version of such brand name drug is available;

(5) engage in spread pricing;

(6) charge a Federal health care program, directly or indirectly or through an affiliate, an amount for a prescription drug claim that exceeds the amount paid to the dispensing pharmacy for that same prescription drug claim, less only a bona fide service fee;

(7) lower, impose a fee, or otherwise make an adjustment to a prescription drug claim at the time the claim for such drug is adjudicated, or after the claim is adjudicated, that in any

way reduces the amount a pharmacy is reimbursed for such drug pursuant to subsection (b), including a fee charged to a pharmacy even if such fee is not tied to a prescription drug claim; or

(8) engage in any practice that bases pharmacy reimbursement for a prescription drug on pharmacy, patient, or any other outcomes, scores, or metrics, provided that nothing shall prohibit pharmacy reimbursement, in addition to reimbursement pursuant to subsection (b), for providing care and services within a pharmacy or a pharmacist's applicable State scope of practice.

(d) Recoupment of funds pursuant to audit.—A pharmacy benefits manager may recoup funds pursuant to an audit in compliance with applicable Federal and State law in which—

(1) an overpayment or misfill was found to have occurred; or

(2) in the case of fraud, provided that all amounts recouped be passed back to the applicable Federal health care program.

(e) Enforcement.—

(1) In general.—A pharmacy benefits manager, or any person acting on behalf of a pharmacy benefits manager, that knowingly and willfully violates this section shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $1,000,000 for each act in violation, or imprisoned for not more than 10 years, or both.

(2) Civil action.—A person may bring a civil action for violation of this section for the person and the United States Government. The action shall be brought in the name of the United States Government. The action may be dismissed only if the court and the United States Attorney General give written consent to the dismissal and their reasons for consenting. Any such action shall be subject to the same terms, conditions, and provisions set forth in section 3730 of title 31, United States Code, which are hereby incorporated into this section for purposes of a civil action brought against a pharmacy benefits manager, or any person acting on behalf of a pharmacy benefits manager, that knowingly and willfully violates this section.

(f) Improving prescription drug transparency under the Medicaid program.—Section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) is amended—

(1) in the subsection heading, by striking "retail" and inserting "covered outpatient drug"; and

(2) in paragraph (1)—

(A) in the paragraph heading, by striking "retail" and inserting "covered outpatient drug";

(B) by striking "and" after the semicolon at the end of paragraph (1)(A)(i) and all that precedes it through "(1)" and inserting the following:

"(1) Determining pharmacy actual acquisition costs.—The Secretary shall conduct a survey of pharmacy drug prices to determine the national average drug acquisition cost as follows:

"(A) Use of vendor.—The Secretary may contract services for—

"(i) with respect to a pharmacy that dispenses covered outpatient drugs, including a retail community pharmacy, mail-order pharmacy, specialty pharmacy, nursing home pharmacy, long-term care facility pharmacy, hospital pharmacy, or clinic pharmacy (but not including a charitable pharmacy or a not-for-profit pharmacy), a monthly survey of such pharmacies to determine the national average drug acquisition cost for covered outpatient drugs; and";

(C) in subparagraph (C)—

(i) in clause (i)—

(I) by striking “retail”; and

(II) by striking “prescription” and inserting “covered outpatient”; and

(ii) in clause (ii), by striking “retail community”;

(D) in subparagraph (D)(ii), by striking “retail”;

(E) in subparagraph (E), by striking the term “retail” each place it appears;

(F) by adding at the end the following new subparagraphs:

“(F) Survey reporting.—Each State shall require any pharmacy in such State to respond to surveys of prices conducted under this subsection if—

"(i) such pharmacy dispenses covered outpatient drugs to individuals receiving benefits under this title; and

"(ii) receives any payment, reimbursement, administrative fee, discount, or rebate related to such dispensing, regardless of whether such payment, reimbursement, administrative fee, discount, or rebate is received from—

“(I) the State;

"(II) a designated entity (as defined in subsection (e)(6)(C)); or

"(III) a pharmacy benefits manager that has a contract with a State or designated entity.

“(G) Survey information.—The Secretary shall make information on national drug acquisition prices obtained under this paragraph publicly available. Such information shall include at least the following:

“(i) The monthly response rate of the surveys conducted pursuant to subparagraph (A), including a list of the pharmacies described in subparagraph (F) that did not respond to such survey.

“(ii) The sampling frame and number of pharmacies sampled monthly.

“(iii) Information on price concessions to each pharmacy, including discounts, rebates, and other price concessions (to the extent that such information is available during the survey period), in aggregate or de-identified form, as determined appropriate by the Secretary.

"(H) Enforcement.—At the discretion of the Secretary, the Secretary (acting through the Inspector General and in collaboration with the Administrator of the Centers for Medicare & Medicaid Services) may enforce non-compliance with this paragraph by a pharmacy through the establishment of penalties until compliance with this paragraph has been completed.

“(I) Limitation on use of applicable non-retail pharmacy pricing information.—No State or Federal health care program shall use pricing information reported by pharmacies other than retail community pharmacies to develop or inform reimbursement rates for retail community pharmacies.

"(J) Report on specialty pharmacies.—Not later than 1 year after the date that this subparagraph takes effect, the Secretary shall submit to Congress a report examining specialty drug coverage and reimbursement under this title, including—

"(i) a description of how State Medicaid programs define specialty drugs and specialty pharmacies;

"(ii) the amount State Medicaid programs pay for specialty drugs;

"(iii) how States and designated entities (as defined in subsection (e)(6)(C)) determine payment for specialty drugs;

"(iv) the settings in which specialty drugs are dispensed to individuals receiving benefits under this title (such as retail community pharmacies or specialty pharmacies);

"(v) the extent to which specialty drugs (as defined by the respective States) are captured in the national average drug acquisition cost survey (or through another process);

"(vi) examples of specialty drug dispensing fees to support the services associated with dispensing such specialty drugs; and

“(vii) recommendations as to how specialty pharmacies should be defined and how data from specialty pharmacies should be incorporated into, stratified within, or

otherwise used in the national average drug acquisition cost survey or any successor survey process."; and

(G) in paragraph (2)—

(i) in subparagraph (A), by inserting "(including payment rates under a designated entity (as defined in subsection (e)(6)(C)))" after "under this title"; and

(ii) in subparagraph (B), by inserting ", and the basis for such dispensing fees" before the semicolon at the end.

(g) Effective date.—This section shall take effect on January 1, 2027.

SEC. 337. PROHIBITION ON UNFAIR PRESCRIPTION DRUG PRICING PRACTICES.

(a) Definitions.—In this section:

(1) Bona fide service fee.—The term "bona fide service fee" has the meaning given that term in section 1860D–12(h)(7)(B) of the Social Security Act (42 U.S.C. 1395w–112(h)(7)(B)).

(2) Commission.—The term “Commission” means the Federal Trade Commission.

(3) Health plan.—The term “health plan” means any group or individual health insurance plan or coverage, including any health insurance plan or coverage sponsored or funded by the Federal Government or the government of any State, Territory, or subdivision thereof.

(4) Pharmacy benefit management services.—The term “pharmacy benefit management services” means, pursuant to a written agreement with a payer or health plan offering group or individual health insurance coverage, directly or through an intermediary, the service of—

(A) negotiating terms and conditions, including rebates and price concessions, with respect to a prescription drug on behalf of the health plan, coverage, or payer; or

(B) managing the prescription drug benefits provided by the health plan, coverage, or payer, which may include formulary management, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, or the provision of related services.

(5) Pharmacy benefit manager.—The term “pharmacy benefit manager” means any entity, affiliate, subsidiary, or agent of a pharmacy benefit manager that provides pharmacy benefit management services on behalf of a health plan, a payer, or health insurance issuer.

(6) Prescription drug.—The term “prescription drug” means—

(A) a drug, as that term is defined in section 201(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)), that is—

(i) approved by the Food and Drug Administration under section 505 of such Act (21 U.S.C. 355); and

(ii) subject to the requirements of section 503(b)(1) of such Act (21 U.S.C. 353(b)(1));

(B) a biological product as that term is defined in section 351 of the Public Health Service Act (42 U.S.C. 262(i)(1)); or

(C) a product that is biosimilar to, or interchangeable with, a biologic product under section 351 of the Public Health Service Act (42 U.S.C. 262(i)).

(b) Prohibition on unfair, deceptive, or abusive prescription drug pricing practices.—

(1) Conduct prohibited.—It shall be unlawful for any pharmacy benefit manager, directly or indirectly, to engage in any of the following activities related to pharmacy benefit management services:

(A) Charge a health plan or payer an amount for a prescription drug's ingredient cost or dispensing fee that is different than the amount the pharmacy benefit manager reimburses a pharmacy for the prescription drug's ingredient cost or dispensing fee, less only a bona fide service fee.

(B) Arbitrarily, unfairly, or deceptively, by contract or any other means, reduce, rescind, or otherwise claw back any reimbursement payment, in whole or in part, to a pharmacist or pharmacy for a prescription drug's ingredient cost or dispensing fee, unless—

(i) the original claim was submitted fraudulently;

(ii) the original claim payment was inconsistent with the reimbursement terms in the contract; or

(iii) the pharmacist services were not rendered by the pharmacy or pharmacist.

(C) Arbitrarily, unfairly, or deceptively, by contract or any other means, increase fees or lower reimbursement to a pharmacy in order to offset reimbursement changes instructed by the Federal Government under any health plan funded by the Federal Government.

(2) Safe harbor.—A pharmacy benefit manager shall not be in violation of paragraph (1) if the pharmacy benefit manager:

(A) passes along or returns 100 percent of any price concession to a health plan or payer, including any rebate, discount, or other price concession; and

(B) provides full and complete disclosure of—

(i) the cost, price, and reimbursement of a prescription drug to each health plan, payer, and pharmacy with which the pharmacy benefit manager has a contract or agreement to provide pharmacy benefit management services;

(ii) each fee, markup, and discount charged or imposed by the pharmacy benefit manager to each health plan, payer, and pharmacy with which the pharmacy benefit manager has a contract or agreement for pharmacy benefit management services; and

(iii) the aggregate amount of all remuneration the pharmacy benefit manager receives from a prescription drug manufacturer for a prescription drug, including any rebate, discount, administration fee, and any other payment or credit obtained or retained by the pharmacy benefit manager, pursuant to a contract or agreement for pharmacy benefit management services to a health plan, payer, or any Federal agency (upon the request of the agency).

(c) Enforcement by the Commission.—

(1) Unfair, deceptive or abusive acts or practices.—A violation of this section shall be treated as a violation of a rule defining an unfair, deceptive or abusive act or practice under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

(2) Powers of the Commission.—

(A) In general.—Except as provided in subparagraph (C), the Commission shall enforce this section in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this section.

(B) Privileges and immunities.—Subject to paragraph (3), any person who violates this section shall be subject to the penalties and entitled to the privileges and immunities provided in the Federal Trade Commission Act.

(C) Nonprofit organizations and insurance.—Notwithstanding section 4 or 6 of the Federal Trade Commission Act (15 U.S.C. 44, 46), section 2 of McCarran-Ferguson Act (15 U.S.C. 1012), or any other jurisdictional limitation of the Commission, the Commission shall also enforce this section, in the same manner provided in subparagraphs (A) and (B) of this paragraph, with respect to—

(i) organizations not organized to carry on business for their own profit or that of their members; and

(ii) the business of insurance, and persons engaged in such business.

(D) Authority preserved.—Nothing in this section shall be construed to limit the authority of the Commission under any other provision of law.

(3) Penalties.—

(A) Additional civil penalty.—In addition to any penalty applicable under the Federal Trade Commission Act (15 U.S.C. 41 et seq.), any person that violates this Act shall be liable for a civil penalty of not more than $1,000,000. Each day of a continuing violation shall be considered a separate violation.

(B) Method.—The penalties provided by subparagraph (A) shall be obtained in the same manner as civil penalties imposed under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

(d) Enforcement by States.—

(1) In general.—If the attorney general of a State has reason to believe that an interest of the residents of the State has been or is being threatened or adversely affected by a practice that violates this section, the attorney general of the State may bring a civil action on behalf of the residents of the State in an appropriate district court of the United States to obtain appropriate relief.

(A) If an attorney general lacks appropriate jurisdiction to bring a civil action, any other officer of a State who is authorized by the State to do so may bring a civil action under paragraph (1), subject to the same requirements and limitations that apply under this subsection to civil actions brought by attorneys general.

(B) The attorney general of a State shall provide written notification, including a copy of the complaint to be filed, to the Commission that the attorney general intends to bring such civil action before initiating a civil action. If prior notification is not feasible, the attorney general shall notify the Commission immediately upon instituting the civil action.

(C) The Commission may intervene in any civil action brought by the attorney general of a State under paragraph. Upon intervening, the Commission may—

(i) be heard on all matters arising in the civil action; and

(ii) file petitions for appeal of a decision in the civil action.

(2) Nothing in this subsection may be construed to prevent the attorney general of a State from exercising the powers conferred on the attorney general by the laws of the State

to conduct investigations, to administer oaths or affirmations, or to compel the attendance of witnesses or the production of documentary or other evidence.

(3) No civil action brought pursuant to this subsection shall conflict with the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(e) Affirmative defense.—

(1) In general.—In an action brought under this section to enforce subsection (b), it shall be an affirmative defense that the conduct alleged to be a violation of subsection (b) was nonpretextual and reasonably necessary to—

(A) prevent a violation of, or comply with, Federal or State law;

(B) protect patient safety; or

(C) protect patient access.

(f) Remedies not exclusive.—Nothing in this section shall be construed to preempt, displace, or supplant any State laws, rules, regulations, or requirements, or the enforcement thereof.

(g) Effective date.—This section shall take effect on January 1, 2027.

SEC. 338. REQUIRING NEGOTIATION OF PRESCRIPTION DRUG PRICES.

(a) Negotiation of drug prices under Medicare part D.—Subsection 1860D–11(i) of the Social Security Act (42 U.S.C. 1395w–111(i)) is amended to read

"(i) Negotiation of lower drug prices.—

“(1) In general.—Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA–PD plan.

“(2) No change in rules for formularies.—

“(A) In general.—Nothing in paragraph (1) shall be construed to authorize the Secretary to establish or require a particular formulary.

“(B) Construction.—Subparagraph (A) shall not be construed as affecting the Secretary's authority to ensure appropriate and adequate access to covered part D drugs under prescription drug plans and under MA–PD plans, including compliance of such plans with formulary requirements under section 1860D–4(b)(3).

“(3) Construction.—Nothing in this subsection shall be construed as preventing the sponsor of a prescription drug plan, or an organization offering an MA–PD plan, from

obtaining a discount or reduction of the price for a covered part D drug below the price negotiated under paragraph (1).".

(b) Negotiation of drug prices under Medicare part B.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(v) Negotiation Of Prices For Drugs And Biologicals.—

"(1) In general.—Notwithstanding any other provision of law, the Secretary shall negotiate a contract with a manufacturer to establish the amount of payment under this part for any drug or biological for which the program under this part is the majority purchaser (as determined under paragraph (2)). The Secretary shall negotiate such contracts with the goal of ensuring appropriate and adequate access to necessary drugs and biologicals for individuals enrolled under this part, while minimizing costs to such individuals and to the program under this part to the greatest extent possible.

"(2) Majority purchaser.—For purposes of paragraph (1), the Secretary shall, by regulation, establish a method to identify, based upon drug utilization rates, any drug or biological for which greater than 50 percent of the units sold by the manufacturer of such drug or biological in the preceding calendar year were provided to individuals enrolled under this part.

"(3) Definitions.—In this subsection:

"(A) Drugs and biologicals.—The term 'drug' and the term 'biological' have the same meaning as provided under section 1861(t).

"(B) Manufacturer.—The term 'manufacturer' has the same meaning as provided under section 1847A(c)(6)(A).".

(c) Payment for least costly alternative for Medicare part B drugs.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking "paragraph (7)" and inserting "paragraphs (7) and (9)"; and

(2) by adding at the end the following new paragraph:

"(9) Treatment of functionally equivalent drugs and biologicals.—In the case of a drug or biological furnished on or after January 1, 2027, for which payment is determined under this section, if the drug or biological is functionally equivalent (as defined by the Secretary) to another drug or biological for which payment is determined under this section, the amount of payment for both such drugs or biologicals shall be equal to the payment amount otherwise determined under this section (without regard to the application of this paragraph) for the least costly of such drugs or biologicals.".

(d) Enforcement, backstops, and savings provisions.—

(1) Good-faith negotiation; penalties for process abuse.—

(A) Duty to negotiate in good faith.—A manufacturer of a drug or biological subject to negotiation under this section shall engage in negotiations with the Secretary in good faith and shall not engage in any act or omission the primary purpose or effect of which is to delay, obstruct, evade, or frustrate the negotiation of an agreement on price.

(B) Process abuse defined.—For purposes of this paragraph, process abuse includes—

(i) refusal to meet or communicate with the Secretary after receipt of a written request to negotiate;

(ii) repeated failure to provide pricing, cost, utilization, or other information reasonably requested by the Secretary within the timeframes specified by the Secretary;

(iii) submission of materially incomplete, misleading, or false information;

(iv) withdrawal from negotiations without good cause after negotiations have commenced;

(v) conditioning agreement on terms unrelated to price or access; or

(vi) any other conduct the Secretary determines, by regulation, constitutes bad-faith negotiation.

(C) Civil monetary penalties.—If the Secretary determines that a manufacturer has engaged in process abuse or has violated a requirement of an agreement or information-submission obligation under this section, the Secretary shall impose—

(i) a civil monetary penalty of $1,000,000 for each day during which such violation continues; and

(ii) in the case of knowingly false information, a civil monetary penalty of $100,000,000 for each item of false information.

(D) Additional remedies.—The penalties under this paragraph are in addition to, and shall not limit, any other remedies or authorities available to the Secretary under this title or any other provision of law.

(2) Fallback price.—If negotiations under subsection (a) or (b) do not result in an agreed-upon price within a reasonable period as determined by the Secretary, the Secretary shall establish a rate for the drug or biological at an amount equal to the lesser of—

(A) the price paid by the Secretary of Veterans Affairs to procure the drug under the laws administered by the Secretary of Veterans Affairs;

(B) the price paid to procure the drug under section 8126 of title 38, United States Code; or

(C) the best price determined under section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) for the drug.

(3) Manufacturer agreements and access to negotiated rates.—As a condition of participation in negotiations under subsection (a) or subsection (b), the Secretary shall enter into an agreement with the manufacturer under which the manufacturer shall—

(A) provide access to the negotiated rate established under this section—

(i) in the case of a drug furnished under part D, to pharmacies, mail order services, and other dispensers at the point of sale for individuals enrolled under a prescription drug plan or MA–PD plan; and

(ii) in the case of a drug or biological furnished under part B, to hospitals, physicians, other providers of services, and suppliers for individuals for whom payment may be made under part B; and

(B) comply with such reporting, access, rebate, and other requirements as the Secretary determines necessary to carry out this section.

(4) Administrative duties.—The Secretary shall establish procedures—

(A) to ensure that the negotiated rate established under this section is applied before any coverage or financial assistance under any other health benefit plan or program and before any other discount;

(B) to compute and apply the negotiated rate across different strengths and dosage forms of a drug or biological and not based solely on formulation, package size, or package type; and

(C) to carry out this section with respect to drugs and biologicals furnished under part D, MA–PD plans, and part B.

(5) Information submission.—The Secretary shall establish a process under which a manufacturer of a drug or biological subject to negotiation under subsection (a) or subsection (b) shall submit pricing, cost, utilization, revenue, and such other information as the Secretary determines reasonably necessary to conduct negotiations and administer this section.

(6) Anti-evasion.—The Secretary may promulgate regulations to prevent evasion of this section, including through product hopping, minor reformulations, changes in dosage form, relabeling, or other strategies intended to avoid negotiation, pricing limits, or enforcement under this section.

(7) Savings clause.—Nothing in this section shall be construed to limit the application of the antitrust laws, consumer protection laws, or any other provision of Federal or State law.

(e) (1) In general.—Part E of title XI of the Social Security Act (42 U.S.C. 1320f et seq.) is repealed.

(2) Conforming amendment.—Section 1860D–11(i) of the Social Security Act (42 U.S.C. 1395w–111(i)), as amended by this section, shall supersede any contrary provision of part E of title XI of such Act.

(3) Transition.—Any agreement, maximum fair price, or other determination in effect under part E of title XI of the Social Security Act (42 U.S.C. 1320f et seq.) on the day before the effective date of this section shall remain in effect until superseded by a price or agreement established under this section or until December 31, 2027, whichever occurs first.

(e) Supersession and transition.—

(1) Continuation of existing cycle.—Nothing in this section shall be construed to disturb or invalidate any selection, negotiation, agreement, maximum fair price, or other determination under part E of title XI of the Social Security Act (42 U.S.C. 1320f et seq.) with respect to a drug or biological selected under such part before February 1, 2027.

(2) No new selections or negotiations under part E.—After January 1, 2027, the Secretary may not under part E of such Act—

(A) publish a list of selected drugs for an initial price applicability year after 2028;

(B) enter into a new agreement with a manufacturer with respect to a drug or biological not selected before January 1, 2027; or

(C) establish a new maximum fair price for a drug or biological not selected before January 1, 2027.

(3) Existing agreements and determinations.—Any agreement, maximum fair price, or other determination in effect under part E of such Act with respect to a drug or biological selected before January 1, 2027, shall remain in effect until superseded by a price or agreement established under this section.

(4) Drug-specific supersession.—Upon the establishment under this section of a price or agreement for a drug or biological that is subject to an agreement, maximum fair price, or other determination under part E of such Act, such part shall cease to apply with respect to that drug or biological.

(5) Conforming rule of construction.—On and after the date of enactment of this Act, this section shall supersede any contrary provision of part E of such Act to the extent necessary to carry out this section.

(6) Repeal.—Effective on the date on which the Secretary certifies that no agreement, maximum fair price, or other determination remains in effect under part E of title XI of the Social Security Act with respect to any drug or biological, such part is repealed.

Subtitle D—Workforce Capacity

SEC. 341. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) In general.—Section 1395ww(h)(9) of title 42, United States Code, is amended:

(1) Increase in residency positions.—In subparagraph (A)(ii)—

(A) in subclause (I), by striking "1,000" and inserting "18,000"; and

(B) in subclause (II), by striking "200" and inserting "3,600".

(2) Expanding hospital access.—In subparagraph (B)(ii), by inserting at the end the following new subclauses:

"(V) Hospitals with which the Secretary cooperates under section 7302(d) of title 38, United States Code.

"(VI) Hospitals that emphasize training in community-based settings or in hospital outpatient departments.".

(3) Increasing hospital limits.—In subparagraph (C) by striking "25" and inserting "100".

(4) Expanding qualifying hospitals.—In subparagraph (F)(ii) by striking "(I) through (IV)" and inserting "(I) through (VI)".

SEC. 342. MINIMUM NURSING HOME STAFFING STANDARDS.

(a) In general.—As a condition of participation in the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act, a skilled nursing facility or nursing facility shall comply with the minimum staffing standards established by the Secretary of Health and Human Services under section 1819(b) and section 1919(b) of such Act, including numeric minimums for nursing hours per resident per day and registered nurse coverage, as in effect on the date of enactment of this Act.

(b) Temporary staffing hardship waiver.—

(1) Authority.—The Secretary may grant a temporary waiver from the numeric staffing minimums described in subsection (a) to a facility that demonstrates an inability to meet such minimums despite documented good-faith recruitment and retention efforts.

(2) Duration.—A waiver under this subsection may be granted for a period not to exceed 12 months and may be renewed once for an additional period not to exceed 12 months.

(3) Hard stop.—No facility may receive waivers under this subsection for an aggregate period exceeding 24 months.

(4) Scope.—A waiver under this subsection shall apply only to numeric staffing minimums and shall not affect compliance obligations relating to resident safety, abuse or neglect prevention, quality of care, or reporting.

(5) Enhanced inspections.—The grant of a waiver under this subsection shall automatically subject the facility to enhanced inspection and oversight during the waiver period, as determined by the Secretary.

(c) Limitation for private equity–owned or extracting facilities.—

(1) In general.—A facility that is owned or controlled, directly or indirectly, by a private equity fund, hedge fund, or similar investment vehicle, or that makes distributions, dividends, management fees, or related-party payments above a threshold determined by the Secretary, may receive not more than one waiver under subsection (b).

(2) Duration.—A waiver under this subsection may not exceed 6 months and shall not be renewed.

(d) Failure to comply after waiver period.—

(1) In general.—If a facility fails to meet the staffing standards described in subsection (a) upon expiration of all waiver eligibility under this section, the Secretary shall take appropriate enforcement action.

(2) Enforcement actions.—Such actions may include restriction on new admissions, coordination of resident transfers, and prioritization of placement in compliant public or nonprofit facilities.

(e) Rule of construction.—Nothing in this section shall be construed to authorize categorical exemptions from minimum staffing standards based on geographic location or facility type.

SEC. 343. PROMOTING 6-YEAR DIRECT-ENTRY MEDICAL PROGRAMS.

(a) Findings.—Congress finds that—

(1) many industrialized nations offer medical education pathways integrating undergraduate and medical training, while the United States remains an outlier in relying predominantly on longer sequential degree structures despite the existence of accredited 6-year and 7-year pathways; and

(2) reducing unnecessary time and cost in physician education, and supporting integrated physician workforce pipelines tied to underserved communities, can expand the long-term supply and geographic distribution of physicians, including in rural areas and health professional shortage areas.

(b) In general.—Part D of subchapter II of chapter 6A of title 42, United States Code, is amended by inserting after subpart xii the following:

“subpart xiii—support of 6-year direct-entry medical programs

"SEC. 256j. Promoting 6-year direct-entry medical programs.

“Sec. 256j. Promoting 6-year direct-entry medical programs.

“(a) Definitions.—In this section:

“(1) Approved 6-year direct-entry medical program.—The term ‘approved 6-year direct-entry medical program’ means an integrated program of education that—

“(A) admits students directly or conditionally from secondary school or early undergraduate study into a combined course of study;

“(B) culminates in the award of both a bachelor’s degree and a medical degree in not more than 6 years; and

“(C) is approved by the Secretary, in consultation with nationally recognized medical education accrediting bodies.

“(2) Eligible entity.—The term ‘eligible entity’ means—

“(A) a medical school offering an approved 6-year direct-entry medical program; or

“(B) a consortium consisting of one or more medical schools and one or more clinical training sites, including a teaching health center, federally qualified health center, rural health clinic, critical access hospital, public hospital, tribal health program, or other clinical training site approved by the Secretary.

“(3) Underserved community.—The term ‘underserved community’ means—

“(A) a health professional shortage area with a designation in effect under section 254e;

“(B) a medically underserved community as defined in section 295p; or

“(C) a rural area as defined in section 1395ww(d)(2)(D).

“(b) Program authorized.—The Secretary shall award grants to eligible entities to establish, expand, or support approved 6-year direct-entry medical programs.

“(c) Use of funds.—An eligible entity receiving a grant under this section may use such grant funds for—

“(1) curriculum development and program administration;

“(2) faculty recruitment, retention, and support;

“(3) expansion of enrollment capacity;

“(4) development or expansion of clinical training partnerships and training sites;

“(5) academic advising, mentoring, tutoring, and student support services;

“(6) recruitment of students from rural areas, health professional shortage areas, medically underserved areas or populations, and low-income backgrounds;

“(7) partnerships supporting transition of graduates into residency training, with priority for primary care and other shortage specialties; and

“(8) other activities approved by the Secretary that further the purposes of this section.

“(d) Priority.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

“(1) serve, or are located in, an underserved community;

“(2) provide substantial clinical training in community-based settings; and

“(3) demonstrate a plan to increase the number of graduates who enter residency training and later practice in underserved communities.

“(e) Conditions of receipt.—As a condition of receiving funds under this section, an eligible entity shall agree to—

“(1) maintain accreditation or other approval required by the Secretary;

“(2) submit to the Secretary a plan describing how the program will reduce unnecessary time and cost in physician education while maintaining educational quality;

“(3) ensure that students receive adequate clinical training, advising, and academic support;

“(4) report such information as the Secretary may require under subsection (f); and

“(5) comply with such other program integrity and accountability requirements as the Secretary may establish by regulation.

“(f) Reports.—

“(1) Annual reports by grantees.—Each eligible entity receiving funds under this section shall submit to the Secretary, at such time and in such manner as the Secretary may require, an annual report containing—

“(A) the number of students enrolled in the program;

“(B) the number of students who completed the program;

“(C) the demographic and geographic characteristics of participating students, including the number recruited from rural areas and underserved communities;

“(D) the clinical training sites used by the program;

“(E) the number and percentage of program graduates who entered residency training; and

“(F) such other information as the Secretary determines appropriate to evaluate the program.

"(2) End of reporting requirement.—Annual reports under this subsection shall be required—

"(A) until each cohort of students supported under the program has either completed the program, withdrawn, or otherwise ceased enrollment; or

"(B) 8 years after the last fiscal year in which the entity receives such funds.

“(3) Report to Congress.—Not later than 3 years after the date of enactment of this section, and every 3 years thereafter, the Secretary shall submit to Congress a report on the operation and outcomes of the program under this section, including recommendations for legislative or administrative action.

“(g) Regulations.—The Secretary shall promulgate regulations to carry out this section.

"(h) Authorization of appropriations.—There are authorized to be appropriated $250,000,000 for the period of fiscal years 2027 through 2031, including $60,000,000 for each of fiscal years 2027 and 2028, $50,000,000 for fiscal year 2029, and $40,000,000 for each of fiscal years 2030 and 2031."

"(A) Administrative expenses.—Of the amounts made available under this subsection for a fiscal year, not more than 5 percent may be used for administrative expenses.".

(c) Stafford loans available.—Section 1087(e)(3)(B) of title 20, United States Code, is amended after "an individual enrolled in" by inserting "an approved 6-year direct-entry medical program as defined in section 256j of title 42, United States Code, or".

SEC. 344. REALLOCATION OF UNUSED WAIVERS TO SERVE RURAL AREAS.

(a) Section 214(l) of the Immigration and Nationality Act (8 U.S.C. 1184(l)) is amended by adding at the end the following:

"(4) (A) Beginning on September 30, 2026, and every September 30 thereafter, each State agency that received a waiver under section 212(e) during the fiscal year that ends on that date shall report to the Secretary of State the total number of such waivers that the State agency did not use during such fiscal year.

"(B) (i) For fiscal year 2027, and each fiscal year thereafter, the Secretary of State shall—

"(I) calculate the total number of unused waivers reported by all State agencies under subparagraph (A); and

"(II) subject to clause (ii), reallocate such waivers for equal distribution among eligible State agencies for use during the subsequent fiscal year as waivers subject to paragraph (1)(D)(ii) (referred to in this paragraph as 'supplemental waivers').

"(ii) In accordance with the 3-year commitment required under paragraph (1)(D), the number of supplemental waivers to be redistributed for use during a subsequent fiscal year shall be the total number of unused waivers described in clause (i)(I) divided by three.

"(C) In reallocating waivers under subparagraph (B), on January 1, 2027, and every January 1 thereafter, the Secretary of State shall inform each eligible State agency of—

"(i) the number of supplemental waivers available to the State agency for the subsequent fiscal year; and

"(ii) the manner in which the supplemental waivers will be distributed.

"(D) Fifty percent of supplemental waivers distributed in a fiscal year shall be used to support positions in one or more facilities that serve patients who reside in medically underserved communities (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)).

"(E) If the number of supplemental waivers distributed under this paragraph in a fiscal year is less than the total number of supplemental waivers available for distribution in the fiscal year, the difference between the number distributed and the number available for distribution shall be added to the total number of supplemental waivers available for distribution in the subsequent fiscal year.

"(F) In this paragraph, the term 'eligible State agency' means a State agency that, in the preceding fiscal year, used not fewer than 30 waivers under section 212(e).".

Subtitle E—Tax Adjustments

SEC. 351. TOBACCO AND NICOTINE TAXES.

(a) Tax parity for roll-your-own tobacco.—Section 5701(g) of the Internal Revenue Code of 1986 is amended by striking "$24.78" and inserting "$49.56".

(b) Tax parity for pipe tobacco.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking "$2.8311 cents" and inserting "$49.56".

(c) Tax parity for smokeless tobacco.—

(1) Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking "$1.51" and inserting "$26.84";

(B) in paragraph (2), by striking "50.33 cents" and inserting "$10.74"; and

(C) by adding at the end the following:

"(3) Smokeless tobacco sold in discrete single-use units.—On discrete single-use units, $100.66 per thousand.".

(2) Section 5702(m) of such Code is amended—

(A) in paragraph (1), by striking "or chewing tobacco" and inserting ", chewing tobacco, or discrete single-use unit";

(B) in paragraphs (2) and (3), by inserting "that is not a discrete single-use unit" before the period in each such paragraph; and

(C) by adding at the end the following:

"(4) Discrete single-use unit.—The term 'discrete single-use unit' means any product containing, made from, or derived from tobacco or nicotine that—

"(A) is not intended to be smoked; and

"(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit.".

(d) (1) Tax parity for cigars.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1) by striking "$50.33" and inserting "$100.66"; and

(B) in paragraph (2) by striking “52.75 percent” and all that follows through the period and inserting the following: “$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.”.

(2) Guidance.—The Secretary of the Treasury, or the Secretary's delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

(3) Conforming amendment.—Section 5702 of such Code is amended by striking subsection (l).

(e) Tax parity for roll-your-own tobacco and certain processed tobacco.—Subsection (o) of section 5702 of the Internal Revenue Code of 1986 is amended by inserting “, and includes processed tobacco that is removed for delivery or delivered to a person other than a person with a permit provided under section 5713, but does not include removals of processed tobacco for exportation” after “wrappers thereof”.

(f) Imposition of tax on nicotine for use in vaping, etc.—

(1) In general.—Section 5701 of the Internal Revenue Code of 1986 is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

“(h) Nicotine.—On taxable nicotine, manufactured in or imported into the United States, there shall be imposed a tax equal to the dollar amount specified in section 5701(b)(1) per 1,810 milligrams of nicotine (and a proportionate tax at the like rate on any fractional part thereof).”.

(2) Taxable nicotine.—Section 5702 of such Code is amended—

(A) in subsection (c) by striking “and roll-your-own tobacco” and inserting “roll-your-own tobacco, and taxable nicotine”; and

(B) by adding at the end the following new subsections:

“(q) Taxable nicotine.—

“(1) In general.—Except as otherwise provided in this subsection, the term ‘taxable nicotine’ means any nicotine which has been extracted, concentrated, or synthesized.

“(2) Exception for products approved by Food and Drug Administration.—Such term shall not include any nicotine if the manufacturer or importer thereof demonstrates to the satisfaction of the Secretary of Health and Human Services that such nicotine will be used in—

“(A) a drug—

"(i) that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act (42 U.S.C. 262); or

"(ii) for which an investigational use exemption has been authorized under section 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i) or under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)); or

"(B) a combination product (as described in section 503(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(g))), the constituent parts of which were approved or cleared under section 505, 510(k), or 515 of such Act.

"(3) Coordination with taxation of other tobacco products.—Tobacco products meeting the definition of cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco in this section shall be classified and taxed as such despite any concentration of the nicotine inherent in those products or any addition of nicotine to those products during the manufacturing process.

"(4) Regulations.—The Secretary shall prescribe such regulations or other guidance as is necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance for coordinating the taxation of tobacco products and taxable nicotine to protect revenue and prevent double taxation.

"(r) Manufacturer of taxable nicotine.—

"(1) In general.—Any person who extracts, concentrates, or synthesizes nicotine shall be treated as a manufacturer of taxable nicotine (and as manufacturing such taxable nicotine).

"(2) Application of rules related to manufacturers of tobacco products.—Any reference to a manufacturer of tobacco products, or to manufacturing tobacco products, shall be treated as including a reference to a manufacturer of taxable nicotine, or to manufacturing taxable nicotine, respectively.".

(g) Increasing tax on cigarettes.—

(1) Small cigarettes.—Section 5701(b)(1) of such Code is amended by striking "$50.33" and inserting "$100.66".

(2) Large cigarettes.—Section 5701(b)(2) of such Code is amended by striking "$105.69" and inserting "$211.38".

(h) Tax rates adjusted for inflation.—Section 5701 of such Code, as previously amended by this section, is further amended by adding at the end the following new subsection:

"(j) Inflation adjustment.—

“(1) In general.—In the case of any calendar year beginning after 2026, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2025’ for ‘calendar year 2016’ in subparagraph (A)(ii) thereof.

“(2) Rounding.—If any amount as adjusted under paragraph (1) is not a multiple of $0.01, such amount shall be rounded to the next highest multiple of $0.01.”.

(i) Floor stocks taxes.—

(1) Imposition of tax.—On tobacco products manufactured in or imported into the United States which are removed before any tax increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) Credit against tax.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(3) Liability for tax and method of payment.—

(A) Liability for tax.—A person holding tobacco products on any tax increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) Method of payment.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) Time for payment.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(4) Articles in foreign trade zones.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the first proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the second proviso of such section 3(a).

(5) Definitions.—For purposes of this subsection—

(A) In general.—Any term used in this subsection which is also used in section 5702 of such Code shall have the same meaning as such term has in such section.

(B) Tax increase date.—The term "tax increase date" means the effective date of any increase in any tobacco product excise tax rate pursuant to the amendments made by this section (other than subsection (i) thereof).

(C) Secretary.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(6) Controlled groups.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) Other laws applicable.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(j) Effective dates.—

(1) In general.—Except as provided in paragraphs (2) through (4), the amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the last day of the month which includes the date of the enactment of this Act.

(2) Discrete single-use units and processed tobacco.—The amendments made by subsections (c)(1)(C), (c)(2), and (e) shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2026.

(3) Cigars.—The amendments made by subsection (d) shall apply to articles removed after December 31, 2026.

(4) Taxable nicotine.—The amendments made by subsection (f) shall apply to articles removed in calendar quarters beginning January 1, 2027.

(k) Transition rule for permit and bond requirements.—A person who is lawfully engaged in business as a manufacturer or importer of taxable nicotine (within the meaning of subchapter A

of chapter 52 of the Internal Revenue Code of 1986, as amended by this section) on the date of the enactment of this Act, first becomes subject to the requirements of subchapter B of chapter 52 of such Code by reason of the amendments made by this section, and submits an application under such subchapter B to engage in such business not later than 90 days after the date of the enactment of this Act, shall not be denied the right to continue carrying on such business by reason of such requirements before final action on such application.

SEC. 352. INCREASE IN FEDERAL ALCOHOL EXCISE TAXES; TRANSFER TO MEDICARE FOR ALL TRUST FUND.

(a) Distilled spirits.—Section 5001(a)(1) of title 26, United States Code, is amended by striking "$13.50" and inserting "$27.00".

(b) Wine.—Section 5041(b) of title 26, United States Code, is amended—

(1) in paragraph (1), by striking "$1.07" and inserting "$2.14";

(2) in paragraph (2), by striking "$1.57" and inserting "$3.14";

(3) in paragraph (3), by striking "$3.15" and inserting "$6.30";

(4) in paragraph (4), by striking "$3.40" and inserting "$6.80";

(5) in paragraph (5), by striking "$3.30" and inserting "$6.60"; and

(6) in paragraph (6), by striking "22.6 cents" and inserting "45.2 cents".

(c) Beer.—Section 5051(a) of title 26, United States Code, is amended—

(1) in paragraph (1)(A)(i), by striking "$16" and inserting "$32";

(2) in paragraph (1)(A)(ii), by striking "$18" and inserting "$36"; and

(3) in paragraph (2)(A), by striking "$3.50" and inserting "$7.00".

(d) Transfer.—There is hereby appropriated to the Medicare for All Trust Fund an amount equal to 50 percent of the increase in receipts attributable to the amendments made by this section, as determined by the Secretary of the Treasury, and the Secretary shall transfer such amount from the general fund of the Treasury to the Medicare for All Trust Fund at such times and in such manner as the Secretary determines appropriate, but not less frequently than quarterly.

(e) Effective date.—The amendments made by this section shall apply to articles removed on or after the first day of the first calendar quarter beginning after the date of enactment of this Act.

SEC. 353. REPEALING RESTRICTIONS ON PROVIDER TAXES.

(a) In general.—Section 1903(w)(4) of the Social Security Act (42 U.S.C. 1396b(w)(4)) is amended—

(1) in subparagraph (C)(ii), by striking ", and for fiscal years beginning on or after October 1, 2026, the applicable percent determined under subparagraph (D) shall be substituted for '6 percent' each place it appears"; and

(2) by striking subparagraph (D).

(POPULIST Act TITLE III, version 1.0, last updated March 13, 2026)