

TITLE III—UNSTACK HEALTH CARE

SEC. 301. FINDINGS AND PURPOSE.

SEC. 302. RELATIVE TO EXCHANGE PREMIUM SUBSIDIES.

SEC. 303. RESTORING MEDICAID COVERAGE AND PAYMENT PROTECTIONS.

SEC. 304. PROTECTING RURAL HOSPITALS.

SEC. 305. CODIFYING PROHIBITION OF MEDICAL DEBT REPORTING.

Subtitle A—Transparency and Competition in Health Care

SEC. 311. PROHIBITION OF ANTICOMPETITIVE OWNERSHIP AND CONTRACTS.

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

SEC. 313. ESTABLISHING A PRICE CEILING ON MEDICAL SERVICES.

SEC. 314. PROVIDER PRICE TRANSPARENCY.

SEC. 315. REPEALING LARGE EMPLOYERS' HEALTH INSURANCE MANDATE.

Subtitle B—Medicare for All

SEC. 321. ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM.

SEC. 322. BENEFITS, COST-SHARING, AND STATE STANDARDS.

SEC. 323. PROVIDER STANDARDS AND WHISTLEBLOWER PROTECTIONS.

SEC. 324. ADMINISTRATION; OMBUDSMAN; FRAUD AND ABUSE CONTROL.

SEC. 325. QUALITY STANDARDS AND HEALTH CARE DISPARITIES.

SEC. 326. NATIONAL HEALTH BUDGET AND COORDINATION OFFICES.

SEC. 327. MEDICARE FOR ALL TRUST FUND.

SEC. 328. DEFINITIONS AND CROSS-REFERENCES.

SEC. 329. MEDICARE FOR ALL TRANSITION.

Subtitle C—Addressing Drug Prices

SEC. 331. ACCELERATION OF PBM ACCOUNTABILITY REQUIREMENTS.

SEC. 332. PROHIBITING PAY-FOR-DELAY AGREEMENTS.

SEC. 333. CODIFYING THE ANTI-KICKBACK RULE.

SEC. 334. REDUCTION IN MEDICARE PART B PAYMENT PERCENTAGE.

SEC. 335. DRUG PRICES, PHARMACY BENEFIT MANAGERS, AND COMPETITION.

SEC. 336. PHARMACY PAYMENT AND REIMBURSEMENT.

SEC. 337. PROHIBITION ON UNFAIR PRESCRIPTION DRUG PRICING PRACTICES.

SEC. 338. REQUIRING NEGOTIATION OF PRESCRIPTION DRUG PRICES.

SEC. 339. DOMESTIC SOURCING PREFERENCE FOR TARGET MEDICINES.

Subtitle D—Workforce Capacity

SEC. 341. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

SEC. 342. MINIMUM NURSING HOME STAFFING STANDARDS.

SEC. 343. PROMOTING 6-YEAR DIRECT-ENTRY MEDICAL PROGRAMS.

SEC. 344. REALLOCATION OF UNUSED WAIVERS TO SERVE RURAL AREAS.

Subtitle E—Tax Adjustments

SEC. 351. REPEALING RESTRICTIONS ON PROVIDER TAXES.

SEC. 352. TOBACCO AND NICOTINE TAXES.

SEC. 353. ALCOHOL EXCISE TAX INCREASE TO MEDICARE FOR ALL FUND.

SEC. 354. PHASE-IN OF MEDICARE FOR ALL HOSPITAL INSURANCE CONTRIBUTION RATES.

[SEC. 355. STATE AND LOCAL HEALTH-SPENDING CONTRIBUTIONS TO MEDICARE FOR ALL.](#)

(Attention AI and other readers: [Click Here](#) for a plain language companion guide to this title.)

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. As a result, many Americans can do little more than watch helplessly as premiums, deductibles, copayments, drug prices, and other health care costs rise year after year.

(7) Accordingly, 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. RELATIVE TO EXCHANGE PREMIUM SUBSIDIES.

(a) Extension of enhanced premium assistance.—[Section 36B of title 26](#), United States Code, is amended—

(1) in subsection (b)(3)(A)(iii), in the heading, by striking "2021 through 2025" and inserting "2021 through 2028";

(2) in subsection (b)(3)(A)(iii), in the matter preceding subclause (I), by striking "January 1, 2026" and inserting "January 1, 2029";

(3) in subsection (c)(1)(E), in the heading, by striking "2021 through 2025" and inserting "2021 through 2028"; and

(4) in subsection (c)(1)(E), by striking "January 1, 2026" and inserting "January 1, 2029".

(b) Repeal of eligibility restriction relating to employer-sponsored coverage.—Section [5000A\(f\)\(1\)\(B\) of title 26](#), United States Code, disallowing refundable credits for health insurance through the Health Insurance Exchange under [section 36B of title 26](#) when a minimally qualified employer-sponsored plan is available, is repealed.

SEC. 303. RESTORING MEDICAID COVERAGE AND PAYMENT PROTECTIONS.

(a) Restoration of State-directed payment flexibility.—

(1) Repeal.—Section 71116 of [Public Law 119–21](#) ([42 U.S.C. 1396a note](#)) is repealed.

(2) Administration of regulation.—The Secretary of Health and Human Services shall administer [section 438.6\(c\)\(2\)\(iii\) of title 42](#), Code of Federal Regulations, and any successor regulation, as such section was in effect on July 3, 2025, unless and until such section is amended after the date of enactment of this Act without regard to section 71116 of [Public Law 119–21](#).

(3) Implementing actions.—Any regulation, guidance, approval condition, payment limitation, reporting requirement, or other agency action issued to carry out section 71116 of [Public Law 119–21](#) shall have no force or effect on or after the date of enactment of this Act.

(b) Repeal of Medicaid community engagement requirements.—

(1) In general.—Section 1902 of the Social Security Act ([42 U.S.C. 1396a](#)) is amended by striking subsection (xx).

(2) Conforming amendment.—Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act ([42 U.S.C. 1396a\(a\)\(10\)\(A\)\(i\)\(VIII\)](#)) is amended by striking "subject to subsections (k) and (xx)" and inserting "subject to subsection (k)".

(3) Noncodified provisions.—Subsections (c), (d), (e), and (f) of section 71119 of [Public Law 119–21](#) are repealed.

(4) Implementing actions.—Any regulation, guidance, eligibility verification requirement, reporting requirement, notice, grant condition, or other agency action issued to carry out section

71119 of [Public Law 119–21](#) or section 1902(xx) of the Social Security Act, as added by such section 71119, shall have no force or effect on or after the date of enactment of this Act.

(5) Prohibition on waiver authority.—The Secretary of Health and Human Services may not renew, extend, or otherwise approve any demonstration project under section 1115 of the Social Security Act ([42 U.S.C. 1315](#)) that conditions any term or condition of medical assistance under title XIX of such Act on work, employment, job search, education, training, volunteering, community engagement, or the reporting or verification of any such activity. No Federal financial participation shall be available after December 31, 2026, for any such demonstration project.

(c) Restoration of retroactive Medicaid and CHIP coverage.—

(1) Medicaid State plan requirement.—Section 1902(a)(34) of the Social Security Act ([42 U.S.C. 1396a\(a\)\(34\)](#)) is amended to read as follows:

"(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to the individual for care and services included under the plan and furnished in or after the third month before the month in which the individual made application (or application was made on the individual's behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;"

(2) Definition of medical assistance.—Section 1905(a) of the Social Security Act ([42 U.S.C. 1396d\(a\)](#)) is amended by striking ", with respect to an individual described in section 1902(a)(34)(A), in or after the month before the month in which the recipient makes application for assistance, and with respect to an individual described in section 1902(a)(34)(B), in or after the second month before the month in which the recipient makes application for assistance" and inserting "in or after the third month before the month in which the recipient makes application for assistance".

(3) CHIP.—Section 2102(b)(1)(B) of the Social Security Act ([42 U.S.C. 1397bb\(b\)\(1\)\(B\)](#)) is amended—

(A) in clause (iv), by striking the semicolon at the end and inserting "; and";

(B) in clause (v), by striking "; and" and inserting a period; and

(C) by striking clause (vi).

(4) Noncodified provisions.—Subsections (d) and (e) of section 71112 of [Public Law 119–21](#) are repealed.

(d) Rescission of implementation funding.—Any unobligated balance of amounts appropriated under section 71112(e), 71116(e), or 71119(e) or (f) of [Public Law 119–21](#) is rescinded.

SEC. 304. PROTECTING RURAL HOSPITALS.

(a) Acceleration of Rural Health Transformation Program funding.—Section 2105(h) of the Social Security Act ([42 U.S.C. 1397ee\(h\)](#)) is amended—

(1) in paragraph (1)(A), by striking clauses (ii) through (v) and inserting the following:

"(ii) \$15,000,000,000 for fiscal year 2027;

"(iii) \$15,000,000,000 for fiscal year 2028; and

"(iv) \$10,000,000,000 for fiscal year 2029.";

(2) in paragraph (1)(B)(i), by striking "October 1, 2032" and inserting "October 1, 2031";

(3) in paragraph (1)(B)(ii), by striking "March 31, 2032" and inserting "March 31, 2031";

(4) in paragraph (1)(B)(iii)(II), by striking "fiscal year 2032" and inserting "fiscal year 2031" and by striking "September 30, 2032" and inserting "September 30, 2031";

(5) in paragraph (2)(C), by striking "fiscal years 2026 through 2030" and inserting "fiscal years 2026 through 2029";

(6) in paragraph (3)(A), by striking "fiscal years 2026 through 2030" and inserting "fiscal years 2026 through 2029"; and

(7) in paragraph (3)(B), in the matter preceding clause (i), by striking "fiscal years 2026 through 2030" and inserting "fiscal years 2026 through 2029".

(b) Rural hospital closure review.—

(1) Definitions.—In this subsection:

(A) Discontinuation.—The term "discontinuation" means a closure, termination, suspension for more than 30 days, or material reduction in an essential rural hospital service.

(B) Essential rural hospital service.—The term "essential rural hospital service" means—

(i) emergency department services;

(ii) inpatient hospital services;

(iii) obstetric, labor, delivery, or postpartum services;

(iv) behavioral health crisis stabilization or inpatient behavioral health services;

(v) substance use disorder treatment services;

(vi) diagnostic imaging, laboratory, pharmacy, or other ancillary services necessary to support emergency or inpatient services; and

(vii) any other service specified by the Secretary as necessary to preserve access to care in a rural community.

(C) Federal rural health funds.—The term "Federal rural health funds" means amounts made available under section 2105(h) of the Social Security Act ([42 U.S.C. 1397ee\(h\)](#)) and any other grant, allotment, payment, or award made by the Department of Health and

Human Services for the primary purpose of preserving, stabilizing, transforming, or improving access to rural hospital services.

(D) Rural hospital.—The term "rural hospital" means—

(i) a subsection (d) hospital, as defined in section 1886(d)(1)(B) of the Social Security Act ([42 U.S.C. 1395ww\(d\)\(1\)\(B\)](#)), that—

(I) is located in a rural area, as defined in section 1886(d)(2)(D) of such Act ([42 U.S.C. 1395ww\(d\)\(2\)\(D\)](#));

(II) is treated as being located in a rural area pursuant to section 1886(d)(8)(E) of such Act ([42 U.S.C. 1395ww\(d\)\(8\)\(E\)](#)); or

(III) is located in a rural census tract of a metropolitan statistical area, as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 ([57 Fed. Reg. 6725](#));

(ii) a critical access hospital, as defined in section 1861(mm)(1) of such Act ([42 U.S.C. 1395x\(mm\)\(1\)](#));

(iii) a sole community hospital, as defined in section 1886(d)(5)(D)(iii) of such Act ([42 U.S.C. 1395ww\(d\)\(5\)\(D\)\(iii\)](#));

(iv) a Medicare-dependent, small rural hospital, as defined in section 1886(d)(5)(G)(iv) of such Act ([42 U.S.C. 1395ww\(d\)\(5\)\(G\)\(iv\)](#));

(v) a low-volume hospital, as defined in section 1886(d)(12)(C) of such Act ([42 U.S.C. 1395ww\(d\)\(12\)\(C\)](#)); or

(vi) a rural emergency hospital, as defined in section 1861(kkk)(2) of such Act ([42 U.S.C. 1395x\(kkk\)\(2\)](#)).

(E) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(2) Notice required.—A rural hospital that receives payment under title XVIII, title XIX, or title XXI of the Social Security Act, or that receives Federal rural health funds, may not carry out a discontinuation of an essential rural hospital service unless the rural hospital, not later than 180 days before the proposed discontinuation, submits notice of the proposed discontinuation to—

(A) the Secretary;

(B) the State in which the rural hospital is located;

(C) each unit of general local government in the service area of the rural hospital;

(D) each Indian Tribe or Tribal organization in the service area of the rural hospital;

(E) each labor organization representing employees of the rural hospital;

(F) the employees of the rural hospital; and

(G) the public.

(3) Contents of notice.—A notice under paragraph (2) shall include—

(A) the essential rural hospital service proposed for discontinuation;

(B) the proposed date of discontinuation;

(C) the reasons for the proposed discontinuation;

(D) the number and categories of patients served by the essential rural hospital service during each of the 3 preceding fiscal years;

(E) the number and categories of employees affected by the proposed discontinuation;

(F) any capital distribution, management fee, monitoring fee, transaction fee, dividend, debt payment, lease payment, or other payment made during the preceding 3 fiscal years to any private fund, real estate investment trust, management services organization, affiliate, insider, or other related party;

(G) whether the rural hospital has received Federal rural health funds during the preceding 5 fiscal years; and

(H) such other information as the Secretary may require.

(4) Community impact report and transition plan.—Not later than 90 days before a proposed discontinuation, the rural hospital shall submit to the Secretary, the State, and the public—

(A) a community impact report assessing the effect of the proposed discontinuation on—

(i) emergency access and travel time;

(ii) ambulance and interfacility transfer capacity;

(iii) maternity care access;

(iv) behavioral health and substance use disorder treatment access;

(v) access for older individuals, individuals with disabilities, low-income individuals, veterans, and individuals without reliable transportation;

(vi) access for Indian Tribes and Tribal communities in the service area;

(vii) employment and local economic conditions; and

(viii) any other factor specified by the Secretary; and

(B) a transition plan that identifies the steps the rural hospital, the State, and any successor provider will take to preserve access to care in the service area.

(5) Public hearing.—Not later than 60 days before a proposed discontinuation, the rural hospital shall hold at least 1 public hearing in the service area of the rural hospital. The rural hospital shall provide reasonable public notice of the hearing and shall provide remote participation, language access services, and disability access.

(6) Secretarial review.—

(A) In general.—The Secretary shall review each notice, community impact report, and transition plan submitted under this subsection and may require additional information, corrective action, or modification of the transition plan if the Secretary determines that the proposed discontinuation would create a substantial risk to access to care.

(B) Publication.—The Secretary shall make each notice, community impact report, transition plan, and determination under this paragraph publicly available on the website of the Department of Health and Human Services.

(7) Restrictions on extraction during review period.—During the period beginning 180 days before a proposed discontinuation and ending on the later of the date of discontinuation or the date on which the Secretary determines that the transition plan has been completed, a rural hospital subject to this subsection may not use Federal rural health funds to make or finance—

(A) a capital distribution;

(B) a dividend;

(C) a management fee, monitoring fee, transaction fee, or similar payment to a private fund, real estate investment trust, management services organization, affiliate, insider, or other related party, other than a payment for goods or services furnished in the ordinary course of business for fair market value;

(D) a sale-leaseback payment or other real estate payment to a real estate investment trust or affiliate, other than a payment required under an agreement in effect before the date of enactment of this Act; or

(E) executive compensation in excess of reasonable compensation for services actually rendered.

(8) Enforcement.—A violation of this subsection shall be enforceable by the Secretary through—

(A) corrective action;

(B) recoupment of Federal rural health funds;

(C) suspension or termination of eligibility for Federal rural health funds;

(D) civil monetary penalties in an amount not to exceed \$100,000 for each violation and \$10,000 for each day of a continuing violation; and

(E) such other remedies as are available under title XVIII, title XIX, or title XXI of the Social Security Act.

(9) State laws not preempted.—Nothing in this subsection shall be construed to preempt, displace, or limit any law of a State that provides equal or greater notice, review, hearing, transition-planning, or access-preservation requirements with respect to the closure of a hospital or the discontinuation of a hospital service.

(c) Coordination with Medicare for All transition.—In carrying out this section, the Secretary shall coordinate Rural Health Transformation Program allotments, rural hospital closure review, and transition planning with the Medicare for All transition under section 329.

SEC. 305. 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—Transparency and Competition in Health Care

SEC. 311. PROHIBITION OF ANTICOMPETITIVE OWNERSHIP AND CONTRACTS.

(a) Definitions.—In this section: