

(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:

(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) Common ownership or control.—The term "common ownership or control" means ownership or control, direct or indirect, of 2 or more entities by the same person or group of persons.

(4) Control.—The term "control" means the possession, direct or indirect, of the power to direct or cause the direction of the management, policies, or operations of an entity. A person shall be rebuttably presumed to control an entity if such person—

(A) owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the entity;

(B) has the power to appoint 25 percent or more of the board of directors or equivalent governing body of the entity; or

(C) possesses contractual or other rights that permit such person to direct or materially influence the strategic, operational, contracting, payment, coverage, utilization management, dispensing, distribution, or access decisions of the entity.

(5) 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](#)).

(6) 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.

(7) 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.

(8) 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](#)).

(9) 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.

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

(11) 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.

(12) Person.—The term "person" has the meaning given the term in section 1 of the Clayton Act ([15 U.S.C. 12](#)).

(13) Pharmacy.—The term "pharmacy" has the meaning given the term "dispenser" in [section 360eee of title 21](#), United States Code.

(14) 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.

(15) 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\(b\)\(1\)](#)).

(16) 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).

(17) 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.

(18) 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.

(19) 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.

(20) 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 the date of enactment of this Act, 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 subparagraph (A).

(2) Rulemaking.—Not later than January 30, 2027, the Commission and the Antitrust Division shall, by joint interim final 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 an activity may be excluded from prohibition under this subsection, except that any exclusion under this subparagraph shall be construed narrowly and shall not permit the preservation, recreation, or continuation of vertically integrated control inconsistent with the purposes of this section;

(B) standards for applying the definitions of "common ownership or control" and "control" under subsection (a), including standards addressing contractual arrangements of operational control, indirect means of control, and functions materially comparable to a health care vertical;

(C) milestones for divestiture to ensure 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 divestiture plan;
- (ii) the length of time the Commission and the Antitrust Division will review such plan;
- (iii) filing of a revised plan, if necessary;
- (iv) notification of the person acquiring such divestiture;
- (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 divestiture; and
- (vi) the completion of such divestiture; and

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

- (i) penalties under subsection (e)(3);
- (ii) appointment of a divestiture trustee for such person under subsection (e)(4); or
- (iii) both clauses (i) and (ii).

(3) Effect of interim final rule.—The interim final rule under paragraph (2) shall take effect upon publication in the Federal Register, shall have the force and effect of law, and may be issued without regard to [section 553 of title 5](#), United States Code. The Commission and the Antitrust Division shall provide a public comment period of not less than 60 days after publication and shall issue final rules not later than October 30, 2027. A delay in issuance or finalization of rules under this paragraph shall not delay, limit, extinguish, or reduce any prohibition, duty, enforcement authority, or divestiture obligation established by this section.

(4) Notice of divestiture requirement.—

(A) In general.—Not later than 60 days after the date of enactment of this Act, the Commission and the Antitrust Division shall, using the best information available, identify each person that the Commission and the Antitrust Division jointly determine is required to divest under subsection (c) and notify such person of the determination.

(B) 60-day notice not exhaustive.—Notwithstanding subparagraph (A), if the Commission and the Antitrust Division later jointly determine, using the best information available, that a person not notified under subparagraph (A) is required to divest under subsection (c), the Commission and the Antitrust Division shall promptly notify such person.

(C) No immunity.—Failure to identify or notify a person under this paragraph shall not limit, extinguish, or otherwise affect any prohibition, duty, enforcement authority, or divestiture obligation established by this section.

(5) Determination upon request.—

(A) Request.—Any person that has not received notice under paragraph (4) may submit to the Commission and the Antitrust Division a written request for a determination of whether that person is required to divest under subsection (c).

(B) Determination.—Not later than the later of 30 days after receipt of a request under subparagraph (A) or the expiration of the 60-day period under paragraph (4)(A), the Commission and the Antitrust Division shall jointly issue to the person a written determination that states whether the person is required to divest under subsection (c). Notice issued under paragraph (4) after receipt of a request under subparagraph (A) shall satisfy this requirement.

(C) No admission or tolling.—Submission of a request under subparagraph (A) shall not—

(i) constitute an admission that the person is subject to subsection (b) or required to divest under subsection (c); or

(ii) toll or extend any prohibition, duty, enforcement authority, divestiture obligation, or deadline under this section.

(6) Judicial review.—

(A) Petition for review.—

(i) Determination.—A person receiving notice under paragraph (4) or a determination under paragraph (5) may, not later than 30 days after receipt of such notice or determination, file a petition for review of the determination in the United States Court of Appeals for the District of Columbia Circuit.

(ii) Failure to act.—A person that submits a request under paragraph (5)(A) and does not receive a written determination within the period required under paragraph (5)(B) may, at any time before receipt of such determination, file a petition in the United States Court of Appeals for the District of Columbia Circuit to compel issuance of the determination.

(B) Application of chapter 7.—[Chapter 7 of title 5](#), United States Code, shall apply to a petition under subparagraph (A). For purposes of such chapter—

(i) a determination under paragraph (4) or (5) shall constitute final agency action; and

(ii) a failure to issue a determination within the period required under paragraph (5)(B) shall constitute agency action unlawfully withheld.

(C) Expedited consideration.—The court shall expedite consideration of a petition filed under subparagraph (A) to the greatest extent practicable.

(c) Divestiture.—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 and the Antitrust Division may require by joint 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) Lead agency.—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) Review criteria.—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) Additional information.—Any request for additional information by an agency shall be made within 30 days of receipt of the plan.

(D) Acquiring person.—

(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 disapproves in writing.

(E) Notice of decision.—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) Review deadline.—Not later than 150 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 divestiture required by subsection (c).

(6) Blocking of actions.—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 materially harm competition or otherwise undermine the purposes of this section.

(e) Enforcement.—

(1) In general.—When the Commission, the Antitrust Division, or an attorney general of a State has reason to believe that a person is in violation of this section or a rule promulgated under this section, the Commission, the Antitrust Division, or the attorney general of the 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 this section or a rule promulgated under this section, 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 this section; and

(B) to pay an amount equal to the net profits derived from any business, asset, operation, or interest subject to divestiture during the period of the violation.

(3) Penalties.—

(A) Written determination and transfer.—If a person knowingly and willfully fails to comply with a milestone specified under subsection (b)(2)(C), the Commission and the Antitrust Division, acting jointly, or the lead agency designated under subsection (d)(2)(A), shall issue a written determination identifying the missed milestone, the month for which escrow is required, the amount required to be transferred, and the method used to calculate such amount. Beginning not later than 15 days after receipt of such written determination, the person shall transfer into escrow on a monthly basis 10 percent of the profits of the person, to be—

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

(ii) deposited into the fund described in subsection (e)(5) if divestiture 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) Authority.—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) Cooperation.—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) Approval.—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 amount paid under paragraph (2)(B) shall be deposited into the Medicare for All Trust Fund established under 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 Committee on the Judiciary and the Committee on Energy and Commerce of the House of Representatives and the Committee on the Judiciary and the Committee on Commerce, Science, and Transportation of the Senate 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'", and by inserting before the period at the end of the paragraph so designated ", 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";

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

(4) by striking "'Acts to regulate commerce'" and inserting "(d) 'Acts to regulate commerce'";

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

(6) by striking "'Banks'" and inserting "(f) 'Banks'", and by moving subsection (f), so designated, 2 ems to the left; and

(7) by striking "'Foreign law enforcement agency'" and inserting "(g) 'Foreign law enforcement agency'", and by moving subsection (g), so designated, 1 em to the left.

SEC. 313. 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 July 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 shall issue interim final rules to carry out this section not later than March 31, 2027. The interim final rules shall take effect upon publication in the Federal Register, shall have the force and effect of law, and may be issued without regard to [section 553 of title 5](#), United States Code.

(A) Public comment and final rules.—The Secretary shall provide a public comment period of not less than 60 days after publication of the interim final rules and shall issue final rules not later than 2 years after the date on which the interim final rules are issued.

(B) No delay.—A delay in issuance or finalization of rules under this paragraph shall not delay, limit, extinguish, or reduce any protection, prohibition, or duty established by this section beginning July 1, 2027.

(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.—

(A) In general.—The Secretary may impose on a provider or payer that violates subsection (d) a civil monetary penalty not to exceed the greater of—

(i) \$10,000 for each claim, bill, or transaction involved in the violation; or

(ii) 3 times the amount charged or paid above the applicable ceiling price.

(B) Continuing violation.—A failure to provide a required refund or otherwise correct a violation after notice from the Secretary shall constitute a separate violation for each day during which the failure continues, subject to a penalty not exceeding \$10,000 for each such day.

(C) Enhanced penalties.—The maximum amounts under subparagraphs (A) and (B) shall be doubled for a repeated, reckless, or knowing violation.

(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. 314. 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 chargemaster or provider of service or supplier's, as applicable, chargemaster (or similar list of prices), 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 (as defined in [section 1861\(e\)](#)), a critical access hospital (as defined in [section 1861\(mm\)\(1\)](#)), or a rural emergency hospital (as defined in [section 1861\(kkk\)](#)).

"(8) Specified imaging service.—The term 'specified imaging service' means an imaging service that is included on the list of Centers for Medicare & Medicaid Services-specified shoppable services (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) each type 2 national provider identifier associated with the hospital or a unit of the hospital; and

"(iv) 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 (as specified by the Secretary) 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) For each such item or service when provided in, as applicable, the inpatient and outpatient department settings—

"(I) the discounted cash price, as applicable, expressed as a dollar amount; or

"(II) in the case no discounted cash price is available for such item or service, the median cash price charged by the hospital (not including charity care) to self-pay individuals for such item or service when provided in such settings for the previous 3 years, expressed as a dollar amount.

"(iv) 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 prices.

"(v) 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.

"(vi) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, not including any such charge that is \$0.

"(vii) Any other additional information the Secretary may require (in consultation with stakeholders) 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 March 31, 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 establish processes to monitor and assess specified hospitals' compliance with this subsection. Such processes shall include processes relating to the following:

"(A) The evaluation and analysis of complaints made by individuals or other entities relating to such hospitals' compliance with this subsection.

"(B) The use of audits to ensure such hospitals' compliance with this subsection.

"(C) The obtaining of additional information from such hospitals to determine such hospitals' compliance with this subsection, as determined appropriate by the Secretary.

"(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 be submitted not later than 45 days after such request is made, 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 60 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 be submitted not later than 45 days after such request is made, 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 (viii), in addition to any other enforcement actions or penalties that may apply under another provision of Federal 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 90 days after such request is made (or, if such hospital has submitted such a corrective action plan not later than 45 days after the date such request was made, by the date that is 90 days after the date of the submission of such corrective action plan), 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 for 2 or more

6-month periods during any 3-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 action 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) Hospitals located in rural or underserved areas.—

"(aa) In general.—Subject to item (bb), 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.

"(bb) Limitation on application.—The Secretary may not elect to waive a penalty under item (aa) 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.

"(II) Reduction if hearing waived.—The Secretary may reduce any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the specified hospital that is the subject of such penalty agrees to waive any right of such hospital to a hearing before an administrative law judge with respect to the imposition of such penalty.

"(v) Hardship exemption.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to a specified hospital on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such hospital's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in [section 602\(a\)](#) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other similar or unexpected catastrophe or similar situation).

"(vi) 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.

"(vii) 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.

"(viii) Nonduplication of certain penalties.—

"(I) In general.—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 subsection 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.

"(II) Prioritization.—In the case of a hospital that the Secretary determines to be in violation of the provisions of this subsection and of section 2718(f) of the Public Health Service Act, the Secretary shall impose penalties as prescribed in such section 2718(f) in lieu of any penalties prescribed in this subsection.

"(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, if practicable, 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, but only to the extent that such rationale does not make public commercially sensitive information; 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 specified hospital pursuant to subsection (b), a hospital pursuant to section 2718(f) of the Public Health Service Act, or an ambulatory surgical center pursuant to section 1834(bb), 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; and

"(C) include on the website described in subparagraph (A) an attestation that all such information is complete and accurate.

"(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 de-identified minimum payer-specific negotiated charge for such service and the de-identified maximum payer-specific negotiated charge for such service.

"(3) Uniform method and format.—Not later than March 31, 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 in a 10-year period.

"(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 this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital making public charges and information pursuant to this section 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 operating within the United States (including a specified hospital (as defined in section 1899D of the Social Security Act)) 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) each type 2 national provider identifier associated with the hospital or a unit of the hospital; and

"(iv) 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 (as specified by the Secretary) 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 (as specified by the Secretary), for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

"(iii) For each such item or service when provided in, as applicable, the inpatient and outpatient department settings—

"(I) the discounted cash price, as applicable, expressed as a dollar amount; or

"(II) in the case no discounted cash price is available for such item or service, the median cash price charged by the hospital (not including charity care) to self-pay individuals for such item or service when provided in such settings for the previous 3 years, expressed as a dollar amount.

"(iv) 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 prices.

"(v) 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.

"(vi) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, not including any such charge that is \$0.

"(vii) Any other additional information the Secretary may require (in consultation with stakeholders) 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 March 31, 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 establish processes to monitor and assess hospitals' compliance with this subsection. Such processes shall include processes relating to the following:

"(A) The evaluation and analysis of complaints made by individuals or other entities relating to such hospitals' compliance with this subsection.

"(B) The use of audits to ensure such hospitals' compliance with this subsection.

"(C) The obtaining of additional information from such hospitals to determine such hospitals' compliance with this subsection, as determined appropriate by the Secretary.

"(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 be submitted not later than 45 days after such request is made, 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 60 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 be submitted not later than 45 days after such request is made, 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 Federal 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 90 days after such request is made (or, if such hospital has submitted such a corrective action plan not later than 45 days after the date such request was made, by the date that is 90 days after the date of the submission of such corrective action plan), 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 for 2 or more 6-month periods during any 3-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 action 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) Hospitals located in rural or underserved areas.—

"(aa) In general.—Subject to item (bb), 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.

"(bb) Limitation on application.—The Secretary may not elect to waive a penalty under item (aa) 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.

"(II) Reduction if hearing waived.—The Secretary may reduce any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the hospital that is the subject of such penalty agrees to waive any right of such hospital to a hearing before an administrative law judge with respect to the imposition of such penalty.

"(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 hospitals requesting such assistance.

"(vi) Hardship exemption.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to a hospital on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such hospital's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in [section 602\(a\)](#) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other similar or unexpected catastrophe or similar situation).

"(vii) Application of certain provisions.—The provisions of [section 1128A](#) of the Social Security Act (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.

"(viii) Nonduplication of penalties.—

"(I) In general.—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.

"(II) Prioritization.—In the case of a hospital that the Secretary determines to be in violation of the provisions of this subsection and of section 1899D of the Social Security Act, the Secretary shall impose penalties as prescribed in this subsection in lieu of any penalties prescribed in such section 1899D.

"(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, if practicable, 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, but only to the extent that such rationale does not make public commercially sensitive information; and

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

"(5) Ensuring accessibility through implementation.—In implementing this subsection, the Secretary shall through rulemaking ensure that a hospital making public charges and prices pursuant to this subsection 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. 1899D. 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; and

"(C) include on the website described in subparagraph (A) an attestation that all such information is complete and accurate.

"(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 de-identified minimum payer-specific negotiated charge between such laboratory and any third-party payer for such test.

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

"(3) Uniform method and format.—Not later than March 31, 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—

"(i) a specified hospital pursuant to section 1899D;

"(ii) a hospital pursuant to section 2718(f) of the Public Health Service Act ([42 U.S.C. 300gg-18](#)); or

"(iii) an ambulatory surgical center pursuant to section 1834(bb).

"(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 (or similar list of prices), 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 an advanced diagnostic laboratory test (as defined in [section 1834A\(d\)\(5\)](#)).

"(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:

"(bb) 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 in a consumer-friendly format (as specified by the Secretary) 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 (as specified by the Secretary) 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;

"(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; and

"(iv) an attestation that all standard charges described in clause (i), information described in clause (ii), and indications described in clause (iii) are 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 an ambulatory surgical center, the following:

"(i) A plain language description (as specified by the Secretary) 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) For each such item or service—

"(I) the discounted cash price, as applicable, expressed as a dollar amount; or

"(II) 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 (in consultation with stakeholders) 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 March 31, 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 described in section 1899D(b)(2)(C)(ii));

"(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 establish processes to monitor and assess ambulatory surgical centers' compliance with this subsection. Such processes shall include processes relating to the following:

"(A) The evaluation and analysis of complaints made by individuals or other entities relating to such centers' compliance with this subsection.

"(B) The use of audits to ensure such centers' compliance with this subsection.

"(C) The obtaining of additional information from such centers to determine such centers' compliance with this subsection, as determined appropriate by the Secretary.

"(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 Federal 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 and has failed to comply with such requirements 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 day (beginning with the day on which the Secretary first determined that such center was not complying with such requirements) 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) Centers located in rural or underserved areas.—

"(aa) In general.—Subject to item (bb), 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 center.

"(bb) Limitation on application.—The Secretary may not elect to waive a penalty under item (aa) 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 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.

"(II) Reduction if hearing waived.—The Secretary may reduce any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the ambulatory surgical center that is the subject of such penalty agrees to waive any right of such center to a hearing before an administrative law judge with respect to the imposition of such penalty.

"(5) Provision of technical assistance.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to ambulatory surgical centers requesting such assistance.

"(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 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."

(d) Implementation and rulemaking.—The Secretary of Health and Human Services shall issue interim final rules to carry out this section and the amendments made by this section not later than March 31, 2027. The interim final rules shall take effect upon publication in the Federal Register, shall have the force and effect of law, and may be issued without regard to [section 553 of title 5](#), United States Code, including with respect to any process that would otherwise be required to be established through notice and comment rulemaking under the amendments made by this section.

(1) Public comment and final rules.—The Secretary shall provide a public comment period of not less than 60 days after publication of the interim final rules and shall issue final rules not later than 2 years after the date on which the interim final rules are issued.

(2) No delay.—A delay in issuance or finalization of rules under this subsection shall not delay, limit, extinguish, or reduce any transparency requirement, enforcement authority, penalty, publication duty, protection, prohibition, or duty established by this section or the amendments made by this section beginning July 1, 2027.

SEC. 315. 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.

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. Not later than December 31, 2026, the Secretary shall issue interim final rules that provide criteria for determining residency for eligibility purposes under this subtitle.

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