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(Original Signature of Member)

119TH CONGRESS
1ST SESSION

H. R. _____

To amend the Internal Revenue Code of 1986 to extend and modify the enhanced premium tax credit, to amend the Patient Protection and Affordable Care Act to make certain adjustments to the operation of the Exchanges established under such Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. KIGGANS of Virginia introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Internal Revenue Code of 1986 to extend and modify the enhanced premium tax credit, to amend the Patient Protection and Affordable Care Act to make certain adjustments to the operation of the Exchanges established under such Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “CommonGround for
5 Affordable Health Care Act”.

1 **SEC. 2. EXTENSION AND MODIFICATION OF ENHANCED**
2 **PREMIUM TAX CREDIT.**

3 (a) EXTENSION AND MODIFICATION OF RULES TO
4 INCREASE PREMIUM ASSISTANCE AMOUNTS.—Section
5 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986
6 is amended—

7 (1) by redesignating subclauses (I) and (II) as
8 items (aa) and (bb), respectively, and adjusting the
9 margins accordingly,

10 (2) by striking “TEMPORARY PERCENTAGES
11 FOR 2021 THROUGH 2025.—In the case of” and in-
12 serting “TEMPORARY PERCENTAGES FOR CERTAIN
13 YEARS.—

14 “(I) BEFORE 2026.—In the case
15 of”, and

16 (3) by adding at the end the following:

17 “(II) 2026.—In the case of a
18 taxable year beginning after Decem-
19 ber 31, 2025, and before January 1,
20 2027—

21 “(aa) clause (ii) shall not
22 apply for purposes of adjusting
23 premium percentages under this
24 subparagraph, and

1 “(bb) the following table
 2 shall be applied in lieu of the
 3 table contained in clause (i):

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
Up to 150%	0.0%	0.0%
150% up to 200%	0.0%	2.0%
200% up to 250%	2.0%	4.0%
250% up to 300%	4.0%	6.0%
300% up to 400%	6.0%	8.5%
400% up to 600%	8.5%	8.5%
600% up to 900%	8.5%	9.25%
900% up to 1000%	9.25%	10.0%”.

4 (b) EXTENSION AND MODIFICATION OF RULE TO
 5 ALLOW CREDIT TO TAXPAYERS WHOSE HOUSEHOLD IN-
 6 COME EXCEEDS 400 PERCENT OF POVERTY LINE.—Sec-
 7 tion 36B(c)(1)(E) of such Code is amended—

8 (1) by striking “TEMPORARY RULE FOR 2021
 9 THROUGH 2025.—In the case of” and inserting
 10 “TEMPORARY RULE FOR CERTAIN YEARS.—

11 “(i) BEFORE 2026.—In the case of”,
 12 and

13 (2) by adding at the end the following:

14 “(ii) 2026.—In the case of a taxable
 15 year beginning after December 31, 2025,
 16 and before January 1, 2027, subparagraph
 17 (A) shall be applied by substituting ‘but
 18 does not exceed 1000 percent’ for ‘but does
 19 not exceed 400 percent’.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2025.

4 **SEC. 3. GUARDRAILS TO PREVENT FRAUD IN EXCHANGES.**

5 (a) REDUCTION OF FRAUDULENT ENROLLMENT IN
6 QUALIFIED HEALTH PLANS.—

7 (1) PENALTIES FOR AGENTS AND BROKERS.—
8 Section 1411(h)(1) of the Patient Protection and Af-
9 fordable Care Act (42 U.S.C. 18081(h)(1)) is
10 amended—

11 (A) in subparagraph (A)—

12 (i) by redesignating clause (ii) as
13 clause (iv);

14 (ii) in clause (i)—

15 (I) in the matter preceding sub-
16 clause (I), by striking “If—” and all
17 that follows through the “such per-
18 son” in the matter following subclause
19 (II) and inserting the following: “If
20 any person (other than an agent or
21 broker) fails to provide correct infor-
22 mation under subsection (b) and such
23 failure is attributable to negligence or
24 disregard of any rules or regulations
25 of the Secretary, such person”; and

1 (II) in the second sentence, by
2 striking “For purposes” and inserting
3 the following:

4 “(iii) DEFINITIONS OF NEGLIGENCE,
5 DISREGARD.—For purposes”;

6 (iii) by inserting after clause (i) the
7 following:

8 “(ii) CIVIL PENALTIES FOR CERTAIN
9 VIOLATIONS BY AGENTS OR BROKERS.—If
10 any agent or broker fails to provide correct
11 information under subsection (b) or section
12 1311(c)(8) or other information, as speci-
13 fied by the Secretary, and such failure is
14 attributable to negligence or disregard of
15 any rules or regulations of the Secretary,
16 such agent or broker shall be subject, in
17 addition to any other penalties that may be
18 prescribed by law, including subparagraph
19 (C), to a civil penalty of not less than
20 \$10,000 and not more than \$50,000 with
21 respect to each individual who is the sub-
22 ject of an application for which such incor-
23 rect information is provided.”; and

24 (iv) in clause (iv) (as so redesignated),
25 by inserting “or (ii)” after “clause (i)”;

1 (B) in subparagraph (B)—

2 (i) by inserting “including subpara-
3 graph (C),” after “law,”;

4 (ii) by striking “Any person” and in-
5 serting the following:

6 “(i) IN GENERAL.—Any person”; and

7 (iii) by adding at the end the fol-
8 lowing:

9 “(ii) CIVIL PENALTIES FOR KNOWING
10 VIOLATIONS BY AGENTS OR BROKERS.—

11 “(I) IN GENERAL.—Any agent or
12 broker who knowingly provides false
13 or fraudulent information under sub-
14 section (b) or section 1311(c)(8), or
15 other false or fraudulent information
16 as part of an application for enroll-
17 ment in a qualified health plan offered
18 through an Exchange, as specified by
19 the Secretary, shall be subject, in ad-
20 dition to any other penalties that may
21 be prescribed by law, including sub-
22 paragraph (C), to a civil penalty of
23 not more than \$200,000 with respect
24 to each individual who is the subject

1 of an application for which such false
2 or fraudulent information is provided.

3 “(II) PROCEDURE.—The provi-
4 sions of section 1128A of the Social
5 Security Act (other than subsections
6 (a) and (b) of such section) shall
7 apply to a civil monetary penalty
8 under subclause (I) in the same man-
9 ner as such provisions apply to a pen-
10 alty or proceeding under section
11 1128A of the Social Security Act.”;
12 and

13 (C) by adding at the end the following:

14 “(C) CRIMINAL PENALTIES.—Any agent or
15 broker who knowingly and willfully provides
16 false or fraudulent information under sub-
17 section (b) or section 1311(c)(8), or other false
18 or fraudulent information as part of an applica-
19 tion for enrollment in a qualified health plan of-
20 fered through an Exchange, as specified by the
21 Secretary, shall be fined under title 18, United
22 States Code, imprisoned for not more than 10
23 years, or both.”.

24 (2) CONSUMER PROTECTIONS.—

1 (A) IN GENERAL.—Section 1311(c) of the
2 Patient Protection and Affordable Care Act (42
3 U.S.C. 18031(c)) is amended by adding at the
4 end the following new paragraph:

5 “(8) AGENT- OR BROKER-ASSISTED ENROLL-
6 MENT IN QUALIFIED HEALTH PLANS IN CERTAIN
7 EXCHANGES.—

8 “(A) IN GENERAL.—For plan years begin-
9 ning on or after such date specified by the Sec-
10 retary, but not later than January 1, 2029, in
11 the case of an Exchange that the Secretary op-
12 erates pursuant to section 1321(c)(1), the Sec-
13 retary shall establish a verification process for
14 new enrollments of individuals in, and changes
15 in coverage for individuals under, a qualified
16 health plan offered through such Exchange,
17 which are submitted by an agent or broker in
18 accordance with section 1312(e) and for which
19 the agent or broker is eligible to receive a com-
20 mission.

21 “(B) REQUIREMENTS.—The enrollment
22 verification process under subparagraph (A)
23 shall include—

24 “(i) a requirement that the agent or
25 broker provide with the new enrollment or

1 coverage change such documentation or
2 evidence (such as a standardized consent
3 form) or other sources as the Secretary de-
4 termines necessary to establish that the
5 agent or broker has the consent of the in-
6 dividual for the new enrollment or coverage
7 change;

8 “(ii) a requirement that any commis-
9 sions due to a broker or agent for such
10 new enrollment or coverage change are
11 paid after the enrollee has resolved all in-
12 consistencies in accordance with para-
13 graphs (3) and (4) of section 1411(e);

14 “(iii) a requirement that the informa-
15 tion required under clause (i) and, as ap-
16 plicable, the date on which inconsistencies
17 are resolved as described in clause (ii), is
18 accessible to the applicable qualified health
19 plan through a database or other resource,
20 as determined by the Secretary, so that
21 any commissions due to a broker or agent
22 for such enrollment can be effectuated at
23 the appropriate time;

24 “(iv) a requirement that individuals
25 are notified of any changes to enrollment,

1 coverage, the agent of record, or premium
2 tax credits in a timely manner and that
3 such notice provides plain language in-
4 structions on how individuals can cancel
5 unauthorized activity;

6 “(v) a requirement that individuals be
7 able to access their account information on
8 a website or other technology platform, as
9 defined by the Secretary, when used to
10 submit an enrollment or plan change, in
11 lieu of the Exchange website described in
12 subsection (d)(4)(C), including information
13 on the agent of record, the qualified health
14 plan, and when any changes are made to
15 the agent of record or the qualified health
16 plan, on a consumer-facing website or
17 through a toll-free telephone hotline; and

18 “(vi) a requirement that the agent or
19 broker report to the Secretary any third-
20 party marketing organization or field mar-
21 keting organization (as such terms are de-
22 fined in section 1312(e)) involved in the
23 chain of enrollment (as so defined) with re-
24 spect to such new enrollment or coverage
25 change.

1 “(C) CONSUMER PROTECTION.—The Sec-
2 retary shall ensure that the enrollment
3 verification process under subparagraph (A)
4 prioritizes continuity of coverage and care for
5 individuals, including by not disenrolling indi-
6 viduals from a qualified health plan without the
7 consent of the individual, regardless of whether
8 the broker, agent, or qualified health plan is in
9 violation of any requirement under this para-
10 graph.”.

11 (B) REQUIRED REPORTING.—Section
12 1311(c)(1) of the Patient Protection and Af-
13 fordable Care Act (42 U.S.C. 18031(c)(1)) is
14 amended—

15 (i) in subparagraph (H), by striking
16 “and” at the end;

17 (ii) in subparagraph (I), by striking
18 the period at the end and inserting “;
19 and”; and

20 (iii) by adding at the end the fol-
21 lowing:

22 “(J) report to the Secretary the termi-
23 nation (as defined in section 1312(e)(1)(C)) of
24 an issuer.”.

1 (3) AUTHORITY TO REGULATE FIELD MAR-
2 KETING ORGANIZATIONS AND THIRD-PARTY MAR-
3 KETING ORGANIZATIONS.—Section 1312(e) of the
4 Patient Protection and Affordable Care Act (42
5 U.S.C. 18032(e)) is amended—

6 (A) by redesignating paragraphs (1) and
7 (2) as subclauses (I) and (II), respectively, and
8 adjusting the margins accordingly;

9 (B) in subclause (II) (as so redesignated),
10 by striking the period at the end and inserting
11 “; and”;

12 (C) by striking the subsection designation
13 and heading and all that follows through “bro-
14 kers—” and inserting the following:

15 “(e) REGULATION OF AGENTS, BROKERS, AND CER-
16 TAIN MARKETING ORGANIZATIONS.—

17 “(1) AGENTS, BROKERS, AND CERTAIN MAR-
18 KETING ORGANIZATIONS.—

19 “(A) IN GENERAL.—The Secretary shall
20 establish procedures under which a State may
21 allow—

22 “(i) agents or brokers—”; and

23 (D) by adding at the end the following:

24 “(ii) field marketing organizations
25 and third-party marketing organizations to

1 participate in the chain of enrollment for
2 an individual with respect to qualified
3 health plans offered through an Exchange.

4 “(B) CRITERIA.—For plan years beginning
5 on or after such date specified by the Secretary,
6 but not later than January 1, 2029, the Sec-
7 retary, by regulation, shall establish criteria for
8 States to use in determining whether to allow
9 agents and brokers to enroll individuals and
10 employers in qualified health plans as described
11 in subclause (I) of subparagraph (A)(i) and to
12 assist individuals as described in subclause (II)
13 of such subparagraph and field marketing orga-
14 nizations and third-party marketing organiza-
15 tions to participate in the chain of enrollment
16 as described in subparagraph (A)(ii). Such cri-
17 teria shall, at a minimum, require that—

18 “(i) an agent or broker act in accord-
19 ance with a standard of conduct that in-
20 cludes a duty of such agent or broker to
21 act in the best interests of the enrollee;

22 “(ii) a field marketing organization or
23 third-party marketing organization agree
24 to report the termination of an agent or
25 broker to the applicable State and the Sec-

1 retary, including the reason for termi-
2 nation; and

3 “(iii) an agent, broker, field mar-
4 keting organization, or third-party mar-
5 keting organization—

6 “(I) meet such marketing re-
7 quirements as are required by the
8 Secretary;

9 “(II) meet marketing require-
10 ments in accordance with other appli-
11 cable Federal or State law;

12 “(III) does not employ practices
13 that are confusing or misleading, as
14 determined by the Secretary;

15 “(IV) submit all marketing mate-
16 rials to the Secretary for, as deter-
17 mined appropriate by the Secretary,
18 review and approval;

19 “(V) is a licensed agent or broker
20 or meets other licensure requirements,
21 as required by the State;

22 “(VI) register with the Secretary;
23 and

24 “(VII) does not compensate any
25 individual or organization for referrals

1 or any other service relating to the
2 sale of, marketing for, or enrollment
3 in qualified health plans unless such
4 individual or organization meets the
5 criteria described in subclauses (I)
6 through (VI).

7 “(C) DEFINITIONS.—In this paragraph:

8 “(i) CHAIN OF ENROLLMENT.—The
9 term ‘chain of enrollment’, with respect to
10 enrollment of an individual in a qualified
11 health plan offered through an Exchange,
12 means any steps taken from marketing to
13 such individual, to such individual making
14 an enrollment decision with respect to such
15 a plan.

16 “(ii) FIELD MARKETING ORGANIZA-
17 TION.—The term ‘field marketing organi-
18 zation’ means an organization or individual
19 that directly employs or contracts with
20 agents and brokers, or contracts with car-
21 riers, to provide functions relating to en-
22 rollment of individuals in qualified health
23 plans offered through an Exchange as part
24 of the chain of enrollment.

1 “(iii) **MARKETING**.—The term ‘mar-
2 keting’ means the use of marketing mate-
3 rials to provide information to current and
4 prospective enrollees in a qualified health
5 plan offered through an Exchange.

6 “(iv) **MARKETING MATERIALS**.—The
7 term ‘marketing materials’ means mate-
8 rials relating to a qualified health plan of-
9 fered through an Exchange or benefits of-
10 fered through an Exchange that—

11 “(I) are intended—

12 “(aa) to draw an individual’s
13 attention to such plan or the pre-
14 mium tax credits or cost-sharing
15 reductions for such plan or plans
16 offered through an Exchange;

17 “(bb) to influence an indi-
18 vidual’s decision-making process
19 when selecting a qualified health
20 plan in which to enroll; or

21 “(cc) to influence an enroll-
22 ee’s decision to stay enrolled in
23 such plan; and

24 “(II) include or address content
25 regarding the benefits, benefit struc-

1 ture, premiums, or cost sharing of
2 such plan.

3 “(v) TERMINATION.—The term ‘ter-
4 mination’, with respect to a contract or
5 business arrangement between an agent or
6 broker and a field marketing organization,
7 third-party marketing organization, or
8 health insurance issuer, means—

9 “(I) the ending of such contract
10 or business arrangement, either uni-
11 laterally by one of the parties or on
12 mutual agreement; or

13 “(II) the expiration of such con-
14 tract or business arrangement that is
15 not replaced by a substantially similar
16 agreement.

17 “(vi) THIRD-PARTY MARKETING ORGA-
18 NIZATION.—The term ‘third-party mar-
19 keting organization’ means an organization
20 or individual that is compensated to per-
21 form lead generation, marketing, or sales
22 relating to enrollment of individuals in
23 qualified health plans offered through an
24 Exchange as part of the chain of enroll-
25 ment.”.

1 (4) TRANSPARENCY.—Section 1312(e) of the
2 Patient Protection and Affordable Care Act (42
3 U.S.C. 18032(e)), as amended by paragraph (3), is
4 further amended by adding at the end the following
5 new paragraphs:

6 “(2) AUDITS.—

7 “(A) IN GENERAL.—For plan years begin-
8 ning on or after such date specified by the Sec-
9 retary, but not later than January 1, 2029, the
10 Secretary, in coordination with the States and
11 in consultation with the National Association of
12 Insurance Commissioners, shall implement a
13 process for the oversight and enforcement of
14 agent and broker compliance with this section
15 and other applicable Federal and State law (in-
16 cluding regulations) that shall include—

17 “(i) periodic audits of agents and bro-
18 kers based on—

19 “(I) complaints filed with the
20 Secretary by individuals enrolled by
21 such an agent or broker in a qualified
22 health plan offered through an Ex-
23 change;

24 “(II) an incident or enrollment
25 pattern that suggests fraud; and

1 “(III) other factors determined
2 by the Secretary; and

3 “(ii) a process under which the Sec-
4 retary shall share audit results and refer
5 potential cases of fraud to the relevant
6 State department of insurance.

7 “(B) EFFECT.—Nothing in this paragraph
8 limits or restricts any referrals made under sec-
9 tion 1311(i)(3) or any enforcement actions
10 under section 1411(h).

11 “(3) LIST.—The Secretary shall develop a proc-
12 ess to regularly provide to qualified health plans,
13 Exchanges, and States a list of suspended and ter-
14 minated agents and brokers.”.

15 (b) REMOVAL OF DECEASED INDIVIDUALS FROM EX-
16 CHANGE PLANS.—Section 1311(c) of the Patient Protec-
17 tion and Affordable Care Act (42 U.S.C. 18031(c)), as
18 amended by subsection (a), is further amended by adding
19 at the end the following new paragraph:

20 “(9) REMOVAL OF DECEASED INDIVIDUALS
21 FROM EXCHANGE PLANS.—

22 “(A) IN GENERAL.—Not later than 90
23 days after the date of the enactment of this
24 paragraph, and on a quarterly basis thereafter,
25 the Secretary shall conduct a check of the

1 Death Master File (as such term is defined in
2 section 203(d) of the Bipartisan Budget Act of
3 2013) for purposes of identifying individuals
4 enrolled in a qualified health plan through an
5 Exchange who are deceased.

6 “(B) PROCESS.—The Secretary shall—

7 “(i) establish a process to verify that
8 an individual identified pursuant to a
9 check described in subparagraph (A) is de-
10 ceased; and

11 “(ii) require an Exchange to termi-
12 nate such individual’s enrollment under a
13 qualified health plan.”.

14 (c) STANDARD OF PROOF FOR TERMINATING
15 AGENTS AND BROKERS.—Section 1312(e) of the Patient
16 Protection and Affordable Care Act (42 U.S.C. 18032(e)),
17 as amended by subsection (a), is further amended by add-
18 ing at the end the following new paragraph:

19 “(4) STANDARD FOR TERMINATION FOR CER-
20 TAIN EXCHANGES.—In the case of an agent or
21 broker with an agreement in effect with an Ex-
22 change operated by the Secretary pursuant to sec-
23 tion 1321(c) to perform activities described in para-
24 graph (1)(A)(i) with respect to such Exchange, the
25 Secretary may terminate such agreement if the Sec-

1 retary finds, based on a preponderance of the evi-
2 dence, that such agent or broker has violated such
3 agreement, otherwise applicable law, or any other re-
4 quirement applicable to such agent or broker.”.

5 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDI-
6 VIDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section
7 1412(c)(2) of the Patient Protection and Affordable Care
8 Act (42 U.S.C. 18082(c)(2)) is amended by adding at the
9 end the following new subparagraph:

10 “(C) EXCHANGE RESPONSIBILITIES.—Be-
11 ginning January 1, 2027, if an Exchange is no-
12 tified under paragraph (1) of an advance deter-
13 mination under section 1411 with respect to the
14 eligibility of an individual for a premium tax
15 credit under section 36B of the Internal Rev-
16 enue Code of 1986, the Exchange shall, prior to
17 enrolling such individual in a qualified health
18 plan, clearly notify such individual of the
19 amount of such tax credit.”.

20 **SEC. 4. EXTENDING ANNUAL OPEN ENROLLMENT PERIOD**
21 **FOR EXCHANGES FOR PLAN YEAR 2026.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services shall revise section 155.410(e) of title 45,
24 Code of Federal Regulations (or any successor regulation)
25 to provide that the annual open enrollment period deter-

1 mined for plan year 2026 pursuant to section 1311(e)(6)
2 of the Patient Protection and Affordable Care Act (42
3 U.S.C. 18031(e)(6)) shall begin on November 1, 2025,
4 and end on March 19, 2026.

5 (b) NOTIFICATION OF OPEN ENROLLMENT EXTEN-
6 SION.—The Secretary of Health and Human Services
7 shall perform such outreach activities as are necessary to
8 inform qualified individuals (as defined in section
9 1312(f)(1) of the Patient Protection and Affordable Care
10 Act (42 U.S.C. 18032(f)(1))) of the extended open enroll-
11 ment period provided for under subsection (a).

12 **SEC. 5. MODERNIZING AND ENSURING PBM ACCOUNT-**
13 **ABILITY.**

14 (a) IN GENERAL.—

15 (1) PRESCRIPTION DRUG PLANS.—Section
16 1860D–12 of the Social Security Act (42 U.S.C.
17 1395w–112) is amended by adding at the end the
18 following new subsection:

19 “(h) REQUIREMENTS RELATING TO PHARMACY BEN-
20 EFIT MANAGERS.—For plan years beginning on or after
21 January 1, 2029:

22 “(1) AGREEMENTS WITH PHARMACY BENEFIT
23 MANAGERS.—Each contract entered into with a
24 PDP sponsor under this part with respect to a pre-
25 scription drug plan offered by such sponsor shall

1 provide that any pharmacy benefit manager acting
2 on behalf of such sponsor has a written agreement
3 with the PDP sponsor under which the pharmacy
4 benefit manager, and any affiliates of such phar-
5 macy benefit manager, as applicable, agree to meet
6 the following requirements:

7 “(A) NO INCOME OTHER THAN BONA FIDE
8 SERVICE FEES.—

9 “(i) IN GENERAL.—The pharmacy
10 benefit manager and any affiliate of such
11 pharmacy benefit manager shall not derive
12 any remuneration with respect to any serv-
13 ices provided on behalf of any entity or in-
14 dividual, in connection with the utilization
15 of covered part D drugs, from any such en-
16 tity or individual other than bona fide serv-
17 ice fees, subject to clauses (ii) and (iii).

18 “(ii) INCENTIVE PAYMENTS.—For the
19 purposes of this subsection, an incentive
20 payment (as determined by the Secretary)
21 paid by a PDP sponsor to a pharmacy
22 benefit manager that is performing serv-
23 ices on behalf of such sponsor shall be
24 deemed a ‘bona fide service fee’ (even if
25 such payment does not otherwise meet the

1 definition of such term under paragraph
2 (7)(B)) if such payment is a flat dollar
3 amount, is consistent with fair market
4 value (as specified by the Secretary), is re-
5 lated to services actually performed by the
6 pharmacy benefit manager or affiliate of
7 such pharmacy benefit manager, on behalf
8 of the PDP sponsor making such payment,
9 in connection with the utilization of cov-
10 ered part D drugs, and meets additional
11 requirements, if any, as determined appro-
12 priate by the Secretary.

13 “(iii) CLARIFICATION ON REBATES
14 AND DISCOUNTS USED TO LOWER COSTS
15 FOR COVERED PART D DRUGS.—Rebates,
16 discounts, and other price concessions re-
17 ceived by a pharmacy benefit manager or
18 an affiliate of a pharmacy benefit manager
19 from manufacturers, even if such price
20 concessions are calculated as a percentage
21 of a drug’s price, shall not be considered a
22 violation of the requirements of clause (i)
23 if they are fully passed through to a PDP
24 sponsor and are compliant with all regu-
25 latory and subregulatory requirements re-

1 lated to direct and indirect remuneration
2 for manufacturer rebates under this part,
3 including in cases where a PDP sponsor is
4 acting as a pharmacy benefit manager on
5 behalf of a prescription drug plan offered
6 by such PDP sponsor.

7 “(iv) EVALUATION OF REMUNERATION
8 ARRANGEMENTS.—Components of subsets
9 of remuneration arrangements (such as
10 fees or other forms of compensation paid
11 to or retained by the pharmacy benefit
12 manager or affiliate of such pharmacy ben-
13 efit manager), as determined appropriate
14 by the Secretary, between pharmacy ben-
15 efit managers or affiliates of such phar-
16 macy benefit managers, as applicable, and
17 other entities involved in the dispensing or
18 utilization of covered part D drugs (includ-
19 ing PDP sponsors, manufacturers, phar-
20 macies, and other entities as determined
21 appropriate by the Secretary) shall be sub-
22 ject to review by the Secretary, in con-
23 sultation with the Office of the Inspector
24 General of the Department of Health and
25 Human Services, as determined appro-

1 appropriate by the Secretary. The Secretary, in
2 consultation with the Office of the Inspec-
3 tor General, shall review whether remu-
4 neration under such arrangements is con-
5 sistent with fair market value (as specified
6 by the Secretary) through reviews and as-
7 sessments of such remuneration, as deter-
8 mined appropriate.

9 “(v) DISGORGEMENT.—The pharmacy
10 benefit manager shall disgorge any remu-
11 neration paid to such pharmacy benefit
12 manager or an affiliate of such pharmacy
13 benefit manager in violation of this sub-
14 paragraph to the PDP sponsor.

15 “(vi) ADDITIONAL REQUIREMENTS.—
16 The pharmacy benefit manager shall—

17 “(I) enter into a written agree-
18 ment with any affiliate of such phar-
19 macy benefit manager, under which
20 the affiliate shall identify and disgorge
21 any remuneration described in clause
22 (v) to the pharmacy benefit manager;
23 and

24 “(II) attest, subject to any re-
25 quirements determined appropriate by

1 the Secretary, that the pharmacy ben-
2 efit manager has entered into a writ-
3 ten agreement described in subclause
4 (I) with any relevant affiliate of the
5 pharmacy benefit manager.

6 “(B) TRANSPARENCY REGARDING GUARAN-
7 TEES AND COST PERFORMANCE EVALUA-
8 TIONS.—The pharmacy benefit manager shall—

9 “(i) define, interpret, and apply, in a
10 fully transparent and consistent manner
11 for purposes of calculating or otherwise
12 evaluating pharmacy benefit manager per-
13 formance against pricing guarantees or
14 similar cost performance measurements re-
15 lated to rebates, discounts, price conces-
16 sions, or net costs, terms such as—

17 “(I) ‘generic drug’, in a manner
18 consistent with the definition of the
19 term under section 423.4 of title 42,
20 Code of Federal Regulations, or a suc-
21 cessor regulation;

22 “(II) ‘brand name drug’, in a
23 manner consistent with the definition
24 of the term under section 423.4 of

1 title 42, Code of Federal Regulations,
2 or a successor regulation;

3 “(III) ‘specialty drug’;

4 “(IV) ‘rebate’; and

5 “(V) ‘discount’;

6 “(ii) identify any drugs, claims, or
7 price concessions excluded from any pric-
8 ing guarantee or other cost performance
9 measure in a clear and consistent manner;
10 and

11 “(iii) where a pricing guarantee or
12 other cost performance measure is based
13 on a pricing benchmark other than the
14 wholesale acquisition cost (as defined in
15 section 1847A(c)(6)(B)) of a drug, cal-
16 culate and provide a wholesale acquisition
17 cost-based equivalent to the pricing guar-
18 antee or other cost performance measure.

19 “(C) PROVISION OF INFORMATION.—

20 “(i) IN GENERAL.—Not later than
21 July 1 of each year, beginning in 2029, the
22 pharmacy benefit manager shall submit to
23 the PDP sponsor, and to the Secretary, a
24 report, in accordance with this subpara-
25 graph, and shall make such report avail-

1 able to such sponsor at no cost to such
2 sponsor in a format specified by the Sec-
3 retary under paragraph (5). Each such re-
4 port shall include, with respect to such
5 PDP sponsor and each plan offered by
6 such sponsor, the following information
7 with respect to the previous plan year:

8 “(I) A list of all drugs covered by
9 the plan that were dispensed includ-
10 ing, with respect to each such drug—

11 “(aa) the brand name, ge-
12 neric or non-proprietary name,
13 and National Drug Code;

14 “(bb) the number of plan
15 enrollees for whom the drug was
16 dispensed, the total number of
17 prescription claims for the drug
18 (including original prescriptions
19 and refills, counted as separate
20 claims), and the total number of
21 dosage units of the drug dis-
22 pensed;

23 “(cc) the number of pre-
24 scription claims described in item
25 (bb) by each type of dispensing

1 channel through which the drug
2 was dispensed, including retail,
3 mail order, specialty pharmacy,
4 long term care pharmacy, home
5 infusion pharmacy, or other types
6 of pharmacies or providers;

7 “(dd) the average wholesale
8 acquisition cost, listed as cost per
9 day’s supply, cost per dosage
10 unit, and cost per typical course
11 of treatment (as applicable);

12 “(ee) the average wholesale
13 price for the drug, listed as price
14 per day’s supply, price per dos-
15 age unit, and price per typical
16 course of treatment (as applica-
17 ble);

18 “(ff) the total out-of-pocket
19 spending by plan enrollees on
20 such drug after application of
21 any benefits under the plan, in-
22 cluding plan enrollee spending
23 through copayments, coinsurance,
24 and deductibles;

1 “(gg) total rebates paid by
2 the manufacturer on the drug as
3 reported under the Detailed DIR
4 Report (or any successor report)
5 submitted by such sponsor to the
6 Centers for Medicare & Medicaid
7 Services;

8 “(hh) all other direct or in-
9 direct remuneration on the drug
10 as reported under the Detailed
11 DIR Report (or any successor re-
12 port) submitted by such sponsor
13 to the Centers for Medicare &
14 Medicaid Services;

15 “(ii) the average pharmacy
16 reimbursement amount paid by
17 the plan for the drug in the ag-
18 gregate and disaggregated by dis-
19 pensing channel identified in item
20 (cc);

21 “(jj) the average National
22 Average Drug Acquisition Cost
23 (NADAC); and

24 “(kk) total manufacturer-de-
25 rived revenue, inclusive of bona

1 fide service fees, attributable to
2 the drug and retained by the
3 pharmacy benefit manager and
4 any affiliate of such pharmacy
5 benefit manager.

6 “(II) In the case of a pharmacy
7 benefit manager that has an affiliate
8 that is a retail, mail order, or spe-
9 cialty pharmacy, with respect to drugs
10 covered by such plan that were dis-
11 pensed, the following information:

12 “(aa) The percentage of
13 total prescriptions that were dis-
14 pensed by pharmacies that are an
15 affiliate of the pharmacy benefit
16 manager for each drug.

17 “(bb) The interquartile
18 range of the total combined costs
19 paid by the plan and plan enroll-
20 ees, per dosage unit, per course
21 of treatment, per 30-day supply,
22 and per 90-day supply for each
23 drug dispensed by pharmacies
24 that are not an affiliate of the
25 pharmacy benefit manager and

1 that are included in the phar-
2 macy network of such plan.

3 “(cc) The interquartile
4 range of the total combined costs
5 paid by the plan and plan enroll-
6 ees, per dosage unit, per course
7 of treatment, per 30-day supply,
8 and per 90-day supply for each
9 drug dispensed by pharmacies
10 that are an affiliate of the phar-
11 macy benefit manager and that
12 are included in the pharmacy
13 network of such plan.

14 “(dd) The lowest total com-
15 bined cost paid by the plan and
16 plan enrollees, per dosage unit,
17 per course of treatment, per 30-
18 day supply, and per 90-day sup-
19 ply, for each drug that is avail-
20 able from any pharmacy included
21 in the pharmacy network of such
22 plan.

23 “(ee) The difference between
24 the average acquisition cost of
25 the affiliate, such as a pharmacy

1 or other entity that acquires pre-
2 prescription drugs, that initially ac-
3 quires the drug and the amount
4 reported under subclause (I)(jj)
5 for each drug.

6 “(ff) A list inclusive of the
7 brand name, generic or non-pro-
8 prietary name, and National
9 Drug Code of covered part D
10 drugs subject to an agreement
11 with a covered entity under sec-
12 tion 340B of the Public Health
13 Service Act for which the phar-
14 macy benefit manager or an affil-
15 iate of the pharmacy benefit
16 manager had a contract or other
17 arrangement with such a covered
18 entity in the service area of such
19 plan.

20 “(III) Where a drug approved
21 under section 505(c) of the Federal
22 Food, Drug, and Cosmetic Act (re-
23 ferred to in this subclause as the ‘list-
24 ed drug’) is covered by the plan, the
25 following information:

1 “(aa) A list of currently
2 marketed generic drugs approved
3 under section 505(j) of the Fed-
4 eral Food, Drug, and Cosmetic
5 Act pursuant to an application
6 that references such listed drug
7 that are not covered by the plan,
8 are covered on the same for-
9 mulary tier or a formulary tier
10 typically associated with higher
11 cost-sharing than the listed drug,
12 or are subject to utilization man-
13 agement that the listed drug is
14 not subject to.

15 “(bb) The estimated average
16 beneficiary cost-sharing under
17 the plan for a 30-day supply of
18 the listed drug.

19 “(cc) Where a generic drug
20 listed under item (aa) is on a for-
21 mulary tier typically associated
22 with higher cost-sharing than the
23 listed drug, the estimated aver-
24 age cost-sharing that a bene-
25 ficiary would have paid for a 30-

1 day supply of each of the generic
2 drugs described in item (aa), had
3 the plan provided coverage for
4 such drugs on the same for-
5 mulary tier as the listed drug.

6 “(dd) A written justification
7 for providing more favorable cov-
8 erage of the listed drug than the
9 generic drugs described in item
10 (aa).

11 “(ee) The number of cur-
12 rently marketed generic drugs
13 approved under section 505(j) of
14 the Federal Food, Drug, and
15 Cosmetic Act pursuant to an ap-
16 plication that references such
17 listed drug.

18 “(IV) Where a reference product
19 (as defined in section 351(i) of the
20 Public Health Service Act) is covered
21 by the plan, the following information:

22 “(aa) A list of currently
23 marketed biosimilar biological
24 products licensed under section
25 351(k) of the Public Health

1 Service Act pursuant to an appli-
2 cation that refers to such ref-
3 erence product that are not cov-
4 ered by the plan, are covered on
5 the same formulary tier or a for-
6 mulary tier typically associated
7 with higher cost-sharing than the
8 reference product, or are subject
9 to utilization management that
10 the reference product is not sub-
11 ject to.

12 “(bb) The estimated average
13 beneficiary cost-sharing under
14 the plan for a 30-day supply of
15 the reference product.

16 “(cc) Where a biosimilar bi-
17 ological product listed under item
18 (aa) is on a formulary tier typi-
19 cally associated with higher cost-
20 sharing than the reference prod-
21 uct, the estimated average cost-
22 sharing that a beneficiary would
23 have paid for a 30-day supply of
24 each of the biosimilar biological
25 products described in item (aa),

1 had the plan provided coverage
2 for such products on the same
3 formulary tier as the reference
4 product.

5 “(dd) A written justification
6 for providing more favorable cov-
7 erage of the reference product
8 than the biosimilar biological
9 product described in item (aa).

10 “(ee) The number of cur-
11 rently marketed biosimilar bio-
12 logical products licensed under
13 section 351(k) of the Public
14 Health Service Act, pursuant to
15 an application that refers to such
16 reference product.

17 “(V) Total gross spending on
18 covered part D drugs by the plan, not
19 net of rebates, fees, discounts, or
20 other direct or indirect remuneration.

21 “(VI) The total amount retained
22 by the pharmacy benefit manager or
23 an affiliate of such pharmacy benefit
24 manager in revenue related to utiliza-
25 tion of covered part D drugs under

1 that plan, inclusive of bona fide serv-
2 ice fees.

3 “(VII) The total spending on cov-
4 ered part D drugs net of rebates, fees,
5 discounts, or other direct and indirect
6 remuneration by the plan.

7 “(VIII) An explanation of any
8 benefit design parameters under such
9 plan that encourage plan enrollees to
10 fill prescriptions at pharmacies that
11 are an affiliate of such pharmacy ben-
12 efit manager, such as mail and spe-
13 cialty home delivery programs, and re-
14 tail and mail auto-refill programs.

15 “(IX) The following information:

16 “(aa) A list of all brokers,
17 consultants, advisors, and audi-
18 tors that receive compensation
19 from the pharmacy benefit man-
20 ager or an affiliate of such phar-
21 macy benefit manager for refer-
22 rals, consulting, auditing, or
23 other services offered to PDP
24 sponsors related to pharmacy
25 benefit management services.

1 “(bb) The amount of com-
2 pensation provided by such phar-
3 macy benefit manager or affiliate
4 to each such broker, consultant,
5 advisor, and auditor.

6 “(cc) The methodology for
7 calculating the amount of com-
8 pensation provided by such phar-
9 macy benefit manager or affil-
10 iate, for each such broker, con-
11 sultant, advisor, and auditor.

12 “(X) A list of all affiliates of the
13 pharmacy benefit manager.

14 “(XI) A summary document sub-
15 mitted in a standardized template de-
16 veloped by the Secretary that includes
17 such information described in sub-
18 clauses (I) through (X).

19 “(ii) WRITTEN EXPLANATION OF CON-
20 TRACTS OR AGREEMENTS WITH DRUG
21 MANUFACTURERS.—

22 “(I) IN GENERAL.—The phar-
23 macy benefit manager shall, not later
24 than 30 days after the finalization of
25 any contract or agreement between

1 such pharmacy benefit manager or an
2 affiliate of such pharmacy benefit
3 manager and a drug manufacturer (or
4 subsidiary, agent, or entity affiliated
5 with such drug manufacturer) that
6 makes rebates, discounts, payments,
7 or other financial incentives related to
8 one or more covered part D drugs or
9 other prescription drugs, as applica-
10 ble, of the manufacturer directly or
11 indirectly contingent upon coverage,
12 formulary placement, or utilization
13 management conditions on any other
14 covered part D drugs or other pre-
15 scription drugs, as applicable, submit
16 to the PDP sponsor a written expla-
17 nation of such contract or agreement.

18 “(II) REQUIREMENTS.—A writ-
19 ten explanation under subclause (I)
20 shall—

21 “(aa) include the manufac-
22 turer subject to the contract or
23 agreement, all covered part D
24 drugs and other prescription
25 drugs, as applicable, subject to

1 the contract or agreement and
2 the manufacturers of such drugs,
3 and a high-level description of
4 the terms of such contract or
5 agreement and how such terms
6 apply to such drugs; and

7 “(bb) be certified by the
8 Chief Executive Officer, Chief Fi-
9 nancial Officer, or General Coun-
10 sel of such pharmacy benefit
11 manager, or affiliate of such
12 pharmacy benefit manager, as
13 applicable, or an individual dele-
14 gated with the authority to sign
15 on behalf of one of these officers,
16 who reports directly to the offi-
17 cer.

18 “(III) DEFINITION OF OTHER
19 PRESCRIPTION DRUGS.—For purposes
20 of this clause, the term ‘other pre-
21 scription drugs’ means prescription
22 drugs covered as supplemental bene-
23 fits under this part or prescription
24 drugs paid outside of this part.

25 “(D) AUDIT RIGHTS.—

1 “(i) IN GENERAL.—Not less than once
2 a year, at the request of the PDP sponsor,
3 the pharmacy benefit manager shall allow
4 for an audit of the pharmacy benefit man-
5 ager to ensure compliance with all terms
6 and conditions under the written agree-
7 ment described in this paragraph and the
8 accuracy of information reported under
9 subparagraph (C).

10 “(ii) AUDITOR.—The PDP sponsor
11 shall have the right to select an auditor.
12 The pharmacy benefit manager shall not
13 impose any limitations on the selection of
14 such auditor.

15 “(iii) PROVISION OF INFORMATION.—
16 The pharmacy benefit manager shall make
17 available to such auditor all records, data,
18 contracts, and other information necessary
19 to confirm the accuracy of information
20 provided under subparagraph (C), subject
21 to reasonable restrictions on how such in-
22 formation must be reported to prevent re-
23 disclosure of such information.

24 “(iv) TIMING.—The pharmacy benefit
25 manager must provide information under

1 clause (iii) and other information, data,
2 and records relevant to the audit to such
3 auditor within 6 months of the initiation of
4 the audit and respond to requests for addi-
5 tional information from such auditor with-
6 in 30 days after the request for additional
7 information.

8 “(v) INFORMATION FROM AFFILI-
9 ATES.—The pharmacy benefit manager
10 shall be responsible for providing to such
11 auditor information required to be reported
12 under subparagraph (C) or under clause
13 (iii) of this subparagraph that is owned or
14 held by an affiliate of such pharmacy ben-
15 efit manager.

16 “(2) ENFORCEMENT.—

17 “(A) IN GENERAL.—Each PDP sponsor
18 shall—

19 “(i) disgorge to the Secretary any
20 amounts disgorged to the PDP sponsor by
21 a pharmacy benefit manager under para-
22 graph (1)(A)(v);

23 “(ii) require, in a written agreement
24 with any pharmacy benefit manager acting
25 on behalf of such sponsor or affiliate of

1 such pharmacy benefit manager, that such
2 pharmacy benefit manager or affiliate re-
3 imburse the PDP sponsor for any civil
4 money penalty imposed on the PDP spon-
5 sor as a result of the failure of the phar-
6 macy benefit manager or affiliate to meet
7 the requirements of paragraph (1) that are
8 applicable to the pharmacy benefit man-
9 ager or affiliate under the agreement; and
10 “(iii) require, in a written agreement
11 with any such pharmacy benefit manager
12 acting on behalf of such sponsor or affil-
13 iate of such pharmacy benefit manager,
14 that such pharmacy benefit manager or af-
15 filiate be subject to punitive remedies for
16 breach of contract for failure to comply
17 with the requirements applicable under
18 paragraph (1).

19 “(B) REPORTING OF ALLEGED VIOLA-
20 TIONS.—The Secretary shall make available and
21 maintain a mechanism for manufacturers, PDP
22 sponsors, pharmacies, and other entities that
23 have contractual relationships with pharmacy
24 benefit managers or affiliates of such pharmacy
25 benefit managers to report, on a confidential

1 basis, alleged violations of paragraph (1)(A) or
2 subparagraph (C).

3 “(C) ANTI-RETALIATION AND ANTI-COER-
4 CION.—Consistent with applicable Federal or
5 State law, a PDP sponsor shall not—

6 “(i) retaliate against an individual or
7 entity for reporting an alleged violation
8 under subparagraph (B); or

9 “(ii) coerce, intimidate, threaten, or
10 interfere with the ability of an individual
11 or entity to report any such alleged viola-
12 tions.

13 “(3) CERTIFICATION OF COMPLIANCE.—

14 “(A) IN GENERAL.—Each PDP sponsor
15 shall furnish to the Secretary (at a time and in
16 a manner specified by the Secretary) an annual
17 certification of compliance with this subsection,
18 as well as such information as the Secretary de-
19 termines necessary to carry out this subsection.

20 “(B) IMPLEMENTATION.—Notwithstanding
21 any other provision of law, the Secretary may
22 implement this paragraph by program instruc-
23 tion or otherwise.

24 “(4) RULE OF CONSTRUCTION.—Nothing in
25 this subsection shall be construed as—

1 “(A) prohibiting flat dispensing fees or re-
2 imbursement or payment for ingredient costs
3 (including customary, industry-standard dis-
4 counts directly related to drug acquisition that
5 are retained by pharmacies or wholesalers) to
6 entities that acquire or dispense prescription
7 drugs; or

8 “(B) modifying regulatory requirements or
9 sub-regulatory program instruction or guidance
10 related to pharmacy payment, reimbursement,
11 or dispensing fees.

12 “(5) STANDARD FORMATS.—

13 “(A) IN GENERAL.—Not later than June
14 1, 2028, the Secretary shall specify standard,
15 machine-readable formats for pharmacy benefit
16 managers to submit annual reports required
17 under paragraph (1)(C)(i).

18 “(B) IMPLEMENTATION.—Notwithstanding
19 any other provision of law, the Secretary may
20 implement this paragraph by program instruc-
21 tion or otherwise.

22 “(6) CONFIDENTIALITY.—

23 “(A) IN GENERAL.—Information disclosed
24 by a pharmacy benefit manager, an affiliate of
25 a pharmacy benefit manager, a PDP sponsor,

1 or a pharmacy under this subsection that is not
2 otherwise publicly available or available for pur-
3 chase shall not be disclosed by the Secretary or
4 a PDP sponsor receiving the information, ex-
5 cept that the Secretary may disclose the infor-
6 mation for the following purposes:

7 “(i) As the Secretary determines nec-
8 essary to carry out this part.

9 “(ii) To permit the Comptroller Gen-
10 eral to review the information provided.

11 “(iii) To permit the Director of the
12 Congressional Budget Office to review the
13 information provided.

14 “(iv) To permit the Executive Direc-
15 tor of the Medicare Payment Advisory
16 Commission to review the information pro-
17 vided.

18 “(v) To the Attorney General for the
19 purposes of conducting oversight and en-
20 forcement under this title.

21 “(vi) To the Inspector General of the
22 Department of Health and Human Serv-
23 ices in accordance with its authorities
24 under the Inspector General Act of 1978

1 (section 406 of title 5, United States
2 Code), and other applicable statutes.

3 “(B) RESTRICTION ON USE OF INFORMA-
4 TION.—The Secretary, the Comptroller General,
5 the Director of the Congressional Budget Of-
6 fice, and the Executive Director of the Medicare
7 Payment Advisory Commission shall not report
8 on or disclose information disclosed pursuant to
9 subparagraph (A) to the public in a manner
10 that would identify—

11 “(i) a specific pharmacy benefit man-
12 ager, affiliate, pharmacy, manufacturer,
13 wholesaler, PDP sponsor, or plan; or

14 “(ii) contract prices, rebates, dis-
15 counts, or other remuneration for specific
16 drugs in a manner that may allow the
17 identification of specific contracting parties
18 or of such specific drugs.

19 “(7) DEFINITIONS.—For purposes of this sub-
20 section:

21 “(A) AFFILIATE.—The term ‘affiliate’
22 means, with respect to any pharmacy benefit
23 manager or PDP sponsor, any entity that, di-
24 rectly or indirectly—

1 “(i) owns or is owned by, controls or
2 is controlled by, or is otherwise related in
3 any ownership structure to such pharmacy
4 benefit manager or PDP sponsor; or

5 “(ii) acts as a contractor, principal, or
6 agent to such pharmacy benefit manager
7 or PDP sponsor, insofar as such con-
8 tractor, principal, or agent performs any of
9 the functions described under subpara-
10 graph (C).

11 “(B) BONA FIDE SERVICE FEE.—The term
12 ‘bona fide service fee’ means a fee that is reflec-
13 tive of the fair market value (as specified by the
14 Secretary, through notice and comment rule-
15 making) for a bona fide, itemized service actu-
16 ally performed on behalf of an entity, that the
17 entity would otherwise perform (or contract for)
18 in the absence of the service arrangement and
19 that is not passed on in whole or in part to a
20 client or customer, whether or not the entity
21 takes title to the drug. Such fee must be a flat
22 dollar amount and shall not be directly or indi-
23 rectly based on, or contingent upon—

1 “(i) drug price, such as wholesale ac-
2 quisition cost or drug benchmark price
3 (such as average wholesale price);

4 “(ii) the amount of discounts, rebates,
5 fees, or other direct or indirect remunera-
6 tion with respect to covered part D drugs
7 dispensed to enrollees in a prescription
8 drug plan, except as permitted pursuant to
9 paragraph (1)(A)(ii);

10 “(iii) coverage or formulary placement
11 decisions or the volume or value of any re-
12 ferrals or business generated between the
13 parties to the arrangement; or

14 “(iv) any other amounts or meth-
15 odologies prohibited by the Secretary.

16 “(C) PHARMACY BENEFIT MANAGER.—The
17 term ‘pharmacy benefit manager’ means any
18 person or entity that, either directly or through
19 an intermediary, acts as a price negotiator or
20 group purchaser on behalf of a PDP sponsor or
21 prescription drug plan, or manages the pre-
22 scription drug benefits provided by such spon-
23 sor or plan, including the processing and pay-
24 ment of claims for prescription drugs, the per-
25 formance of drug utilization review, the proc-

1 essing of drug prior authorization requests, the
2 adjudication of appeals or grievances related to
3 the prescription drug benefit, contracting with
4 network pharmacies, controlling the cost of cov-
5 ered part D drugs, or the provision of related
6 services. Such term includes any person or enti-
7 ty that carries out one or more of the activities
8 described in the preceding sentence, irrespective
9 of whether such person or entity calls itself a
10 ‘pharmacy benefit manager’.”.

11 (2) MA–PD PLANS.—Section 1857(f)(3) of the
12 Social Security Act (42 U.S.C. 1395w–27(f)(3)) is
13 amended by adding at the end the following new
14 subparagraph:

15 “(F) REQUIREMENTS RELATING TO PHAR-
16 MACY BENEFIT MANAGERS.—For plan years be-
17 ginning on or after January 1, 2029, section
18 1860D–12(h).”.

19 (3) NONAPPLICATION OF PAPERWORK REDUC-
20 TION ACT.—Chapter 35 of title 44, United States
21 Code, shall not apply to the implementation of this
22 subsection.

23 (4) FUNDING.—

24 (A) SECRETARY.—In addition to amounts
25 otherwise available, there is appropriated to the

1 Centers for Medicare & Medicaid Services Pro-
2 gram Management Account, out of any money
3 in the Treasury not otherwise appropriated,
4 \$113,000,000 for fiscal year 2026, to remain
5 available until expended, to carry out this sub-
6 section.

7 (B) OIG.—In addition to amounts other-
8 wise available, there is appropriated to the In-
9 spector General of the Department of Health
10 and Human Services, out of any money in the
11 Treasury not otherwise appropriated,
12 \$20,000,000 for fiscal year 2026, to remain
13 available until expended, to carry out this sub-
14 section.

15 (b) GAO STUDY AND REPORT ON PRICE-RELATED
16 COMPENSATION ACROSS THE SUPPLY CHAIN.—

17 (1) STUDY.—The Comptroller General of the
18 United States (in this subsection referred to as the
19 “Comptroller General”) shall conduct a study de-
20 scribing the use of compensation and payment struc-
21 tures related to a prescription drug’s price within
22 the retail prescription drug supply chain in part D
23 of title XVIII of the Social Security Act (42 U.S.C.
24 1395w–101 et seq.). Such study shall summarize in-
25 formation from Federal agencies and industry ex-

1 perts, to the extent available, with respect to the fol-
2 lowing:

3 (A) The type, magnitude, other features
4 (such as the pricing benchmarks used), and
5 prevalence of compensation and payment struc-
6 tures related to a prescription drug's price,
7 such as calculating fee amounts as a percentage
8 of a prescription drug's price, between inter-
9 mediaries in the prescription drug supply chain,
10 including—

11 (i) pharmacy benefit managers;

12 (ii) PDP sponsors offering prescrip-
13 tion drug plans and Medicare Advantage
14 organizations offering MA–PD plans;

15 (iii) drug wholesalers;

16 (iv) pharmacies;

17 (v) manufacturers;

18 (vi) pharmacy services administrative
19 organizations;

20 (vii) brokers, auditors, consultants,
21 and other entities that—

22 (I) advise PDP sponsors offering
23 prescription drug plans and Medicare
24 Advantage organizations offering MA–

1 PD plans regarding pharmacy bene-
2 fits; or

3 (II) review PDP sponsor and
4 Medicare Advantage organization con-
5 tracts with pharmacy benefit man-
6 agers; and

7 (viii) other service providers that con-
8 tract with any of the entities described in
9 clauses (i) through (vii) that may use
10 price-related compensation and payment
11 structures, such as rebate aggregators (or
12 other entities that negotiate or process
13 price concessions on behalf of pharmacy
14 benefit managers, plan sponsors, or phar-
15 macies).

16 (B) The primary business models and com-
17 pensation structures for each category of inter-
18 mediary described in subparagraph (A).

19 (C) Variation in price-related compensation
20 structures between affiliated entities (such as
21 entities with common ownership, either full or
22 partial, and subsidiary relationships) and unaf-
23 filiated entities.

24 (D) Potential conflicts of interest among
25 contracting entities related to the use of pre-

1 prescription drug price-related compensation struc-
2 tures, such as the potential for fees or other
3 payments set as a percentage of a prescription
4 drug's price to advantage formulary selection,
5 distribution, or purchasing of prescription drugs
6 with higher prices.

7 (E) Notable differences, if any, in the use
8 and level of price-based compensation struc-
9 tures over time and between different market
10 segments, such as under part D of title XVIII
11 of the Social Security Act (42 U.S.C. 1395w-
12 101 et seq.) and the Medicaid program under
13 title XIX of such Act (42 U.S.C. 1396 et seq.).

14 (F) The effects of drug price-related com-
15 pensation structures and alternative compensa-
16 tion structures on Federal health care programs
17 and program beneficiaries, including with re-
18 spect to cost-sharing, premiums, Federal out-
19 lays, biosimilar and generic drug adoption and
20 utilization, drug shortage risks, and the poten-
21 tial for fees set as a percentage of a drug's
22 price to advantage the formulary selection, dis-
23 tribution, or purchasing of drugs with higher
24 prices.

1 (G) Other issues determined to be relevant
2 and appropriate by the Comptroller General.

3 (2) REPORT.—Not later than 2 years after the
4 date of enactment of this section, the Comptroller
5 General shall submit to Congress a report containing
6 the results of the study conducted under paragraph
7 (1), together with recommendations for such legisla-
8 tion and administrative action as the Comptroller
9 General determines appropriate.

10 (c) MEDPAC REPORTS ON AGREEMENTS WITH
11 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-
12 SCRIPTIION DRUG PLANS AND MA–PD PLANS.—

13 (1) IN GENERAL.—The Medicare Payment Ad-
14 visory Commission shall submit to Congress the fol-
15 lowing reports:

16 (A) INITIAL REPORT.—Not later than the
17 first March 15 occurring after the date that is
18 2 years after the date on which the Secretary
19 makes the data available to the Commission, a
20 report regarding agreements with pharmacy
21 benefit managers with respect to prescription
22 drug plans and MA–PD plans. Such report
23 shall include, to the extent practicable—

24 (i) a description of trends and pat-
25 terns, including relevant averages, totals,

1 and other figures for the types of informa-
2 tion submitted;

3 (ii) an analysis of any differences in
4 agreements and their effects on plan en-
5 rollee out-of-pocket spending and average
6 pharmacy reimbursement, and other im-
7 pacts; and

8 (iii) any recommendations the Com-
9 mission determines appropriate.

10 (B) FINAL REPORT.—Not later than 2
11 years after the date on which the Commission
12 submits the initial report under subparagraph
13 (A), a report describing any changes with re-
14 spect to the information described in subpara-
15 graph (A) over time, together with any rec-
16 ommendations the Commission determines ap-
17 propriate.

18 (2) FUNDING.—In addition to amounts other-
19 wise available, there is appropriated to the Medicare
20 Payment Advisory Commission, out of any money in
21 the Treasury not otherwise appropriated,
22 \$1,000,000 for fiscal year 2026, to remain available
23 until expended, to carry out this subsection.

1 **SEC. 6. EXPEDITED CONSIDERATION OF ENHANCED PRE-**
2 **MIUM TAX CREDIT REFORM BILL.**

3 (a) QUALIFYING LEGISLATION.—

4 (1) IN GENERAL.—Only an enhanced premium
5 tax credit reform bill shall be entitled to expedited
6 consideration under this section.

7 (2) DEFINITION.—In this section, the term
8 “enhanced premium tax credit reform bill” means a
9 bill or joint resolution which consists solely of legis-
10 lative language with respect to continued health in-
11 surance premium savings, including more significant
12 reforms, that has accumulated at least 10 cospon-
13 sors from each of the majority party and the minor-
14 ity party at the time it is offered.

15 (b) CONSIDERATION IN THE HOUSE OF REPRESENT-
16 ATIVES.—

17 (1) REFERRAL AND REPORTING.—Any com-
18 mittee of the House of Representatives to which an
19 enhanced premium tax credit reform bill is referred
20 shall report the enhanced premium tax credit reform
21 bill to the House of Representatives without amend-
22 ment not later than 5 legislative days after the date
23 on which the enhanced premium tax credit reform
24 bill was so referred. If a committee of the House of
25 Representatives fails to report an enhanced premium
26 tax credit reform bill within that period, that com-

1 mittee shall be automatically discharged from con-
2 sideration of the enhanced premium tax credit re-
3 form bill, and the enhanced premium tax credit re-
4 form bill shall be placed on the appropriate calendar.

5 (2) PROCEEDING TO CONSIDERATION.—After
6 the last committee authorized to consider an en-
7 hanced premium tax credit reform bill reports it to
8 the House of Representatives or has been discharged
9 from its consideration, it shall be in order to move
10 to proceed to consider the enhanced premium tax
11 credit reform bill in the House of Representatives.
12 Such a motion shall not be in order after the House
13 of Representatives has disposed of a motion to pro-
14 ceed with respect to the enhanced premium tax cred-
15 it reform bill. The previous question shall be consid-
16 ered as ordered on the motion to its adoption with-
17 out intervening motion. The motion shall not be de-
18 batable. A motion to reconsider the vote by which
19 the motion is disposed of shall not be in order.

20 (3) VOTE ON PASSAGE.—The vote on passage
21 of the enhanced premium tax credit reform bill shall
22 occur not later than 3 legislative days after the date
23 on which the last committee authorized to consider
24 the enhanced premium tax credit reform bill reports
25 it to the House of Representatives or is discharged.

1 (c) EXPEDITED PROCEDURE IN THE SENATE.—

2 (1) COMMITTEE CONSIDERATION.—An en-
3 hanced premium tax credit reform bill introduced in
4 the Senate shall be jointly referred to the committee
5 or committees of jurisdiction, which committees shall
6 report the enhanced premium tax credit reform bill
7 without any revision and with a favorable rec-
8 ommendation, an unfavorable recommendation, or
9 without recommendation, not later than 5 session
10 days after the date on which the enhanced premium
11 tax credit reform bill was so referred. If any com-
12 mittee to which an enhanced premium tax credit re-
13 form bill is referred fails to report the enhanced pre-
14 mium tax credit reform bill within that period, that
15 committee shall be automatically discharged from
16 consideration of the enhanced premium tax credit re-
17 form bill, and the enhanced premium tax credit re-
18 form bill shall be placed on the appropriate calendar.

19 (2) PROCEEDING.—Notwithstanding rule XXII
20 of the Standing Rules of the Senate, it is in order,
21 not later than 2 days of session after the date on
22 which an enhanced premium tax credit reform bill is
23 reported or discharged from all committees to which
24 the enhanced premium tax credit reform bill was re-
25 ferred, for the majority leader of the Senate or the

1 designee of the majority leader to move to proceed
2 to the consideration of the enhanced premium tax
3 credit reform bill. It shall also be in order for any
4 Member of the Senate to move to proceed to the
5 consideration of the enhanced premium tax credit re-
6 form bill at any time after the conclusion of such 2-
7 day period. A motion to proceed is in order even
8 though a previous motion to the same effect has
9 been disagreed to. All points of order against the
10 motion to proceed to the enhanced premium tax
11 credit reform bill are waived. The motion to proceed
12 is not debatable. The motion is not subject to a mo-
13 tion to postpone. A motion to reconsider the vote by
14 which the motion is agreed to or disagreed to shall
15 not be in order. If a motion to proceed to the consid-
16 eration of the enhanced premium tax credit reform
17 bill is agreed to, the enhanced premium tax credit
18 reform bill shall remain the unfinished business until
19 disposed of. All points of order against an enhanced
20 premium tax credit reform bill and against consider-
21 ation of the enhanced premium tax credit reform bill
22 are waived.

23 (d) CONSIDERATION BY THE OTHER HOUSE.—

24 (1) IN GENERAL.—If, before passing an en-
25 hanced premium tax credit reform bill, a House re-

1 ceives from the other House an enhanced premium
2 tax credit reform bill of the other House—

3 (A) the enhanced premium tax credit re-
4 form bill of the other House shall not be re-
5 ferred to a committee; and

6 (B) the procedure in the receiving House
7 shall be the same as if no enhanced premium
8 tax credit reform bill had been received from
9 the other House until the vote on passage, when
10 the enhanced premium tax credit reform bill re-
11 ceived from the other House shall supplant the
12 enhanced premium tax credit reform bill of the
13 receiving House.

14 (2) REVENUE MEASURES.—This subsection
15 shall not apply to the House of Representatives if an
16 enhanced premium tax credit reform bill received
17 from the Senate is a revenue measure.

18 (e) RULES TO COORDINATE ACTION WITH OTHER
19 HOUSE.—

20 (1) TREATMENT OF ENHANCED PREMIUM TAX
21 CREDIT REFORM BILL OF OTHER HOUSE.—If an en-
22 hanced premium tax credit reform bill is not intro-
23 duced in the Senate or the Senate fails to consider
24 an enhanced premium tax credit reform bill under
25 this section, the enhanced premium tax credit re-

1 form bill of the House of Representatives shall be
2 entitled to expedited floor procedures under this sec-
3 tion.

4 (2) TREATMENT OF COMPANION MEASURES IN
5 THE SENATE.—If, following passage of an enhanced
6 premium tax credit reform bill in the Senate, the
7 Senate then receives from the House of Representa-
8 tives an enhanced premium tax credit reform bill,
9 the House-passed enhanced premium tax credit re-
10 form bill shall not be debatable. The vote on passage
11 of the enhanced premium tax credit reform bill in
12 the Senate shall be considered to be the vote on pas-
13 sage of the enhanced premium tax credit reform bill
14 received from the House of Representatives.

15 (3) VETOES.—If the President vetoes an en-
16 hanced premium tax credit reform bill, consideration
17 of a veto message in the Senate under this para-
18 graph shall be 10 hours equally divided between the
19 majority and minority leaders of the Senate or the
20 designees of the majority and minority leaders of the
21 Senate.

22 (f) VOTE ON PASSAGE.—The vote on final passage
23 in the House of Representatives and the Senate of the en-
24 hanced premium tax credit reform bill shall occur not later
25 than July 1, 2026.

1 (g) EXERCISE OF RULEMAKING POWER.—This sec-
2 tion is enacted by Congress—

3 (1) as an exercise of the rulemaking power of
4 the Senate and House of Representatives, respec-
5 tively, and as such it is deemed a part of the rules
6 of each House, respectively, but applicable only with
7 respect to the procedure to be followed in that
8 House in the case of an enhanced premium tax cred-
9 it reform bill, and it supersedes other rules only to
10 the extent that it is inconsistent with such rules; and

11 (2) with full recognition of the constitutional
12 right of either House to change the rules (so far as
13 relating to the procedure of that House) at any time,
14 in the same manner, and to the same extent as in
15 the case of any other rule of that House.