

119TH CONGRESS
1ST SESSION

H. R. 6575

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

DECEMBER 10, 2025

Mrs. KIGGANS of Virginia (for herself, Mr. GOTTHEIMER, Mr. LAWLER, Mr. CUELLAR, Mr. BRESNAHAN, Mr. SUOZZI, Mr. MACKENZIE, Ms. LEE of Nevada, Ms. SALAZAR, Mr. LANDSMAN, Mr. VAN DREW, Mr. CASE, Mr. CISCOMANI, Mr. COSTA, Mr. VALADAO, Mr. RILEY of New York, Mr. HURD of Colorado, Ms. SCHOLTEN, Mr. BACON, Ms. WILSON of Florida, Mr. GIMENEZ, Ms. GOODLANDER, Ms. DE LA CRUZ, Mr. SOTO, Mr. LALOTA, Mr. GRAY, Mr. KILEY of California, Mr. VICENTE GONZALEZ of Texas, Mr. KEAN, Mr. FIGURES, Mr. FITZPATRICK, Mr. PAPPAS, Mr. LICCARDO, Mr. DAVIS of North Carolina, Mr. MOSKOWITZ, Mr. PANNETTA, Mr. PETERS, and Mr. GOLDEN of Maine) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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”.

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

8 (a) EXTENSION AND MODIFICATION OF RULES TO
 9 INCREASE PREMIUM ASSISTANCE AMOUNTS.—Section
 10 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986
 11 is amended—

12 (1) by redesignating subclauses (I) and (II) as
 13 items (aa) and (bb), respectively, and adjusting the
 14 margins accordingly,

15 (2) by striking “TEMPORARY PERCENTAGES
 16 FOR 2021 THROUGH 2025.—In the case of” and in-
 17 serting “TEMPORARY PERCENTAGES FOR CERTAIN
 18 YEARS.—

19 “(I) BEFORE 2026.—In the case
 20 of”, and

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

22 “(II) 2026.—In the case of a
 23 taxable year beginning after Decem-
 24 ber 31, 2025, and before January 1,
 25 2027—

1 “(aa) clause (ii) shall not
 2 apply for purposes of adjusting
 3 premium percentages under this
 4 subparagraph, and
 5 “(bb) the following table
 6 shall be applied in lieu of the
 7 table contained in clause (i):

“In the case of household income (expressed as a percent of poverty line) within the following in- come 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%”.

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

12 (1) by striking “TEMPORARY RULE FOR 2021
 13 THROUGH 2025.—In the case of” and inserting
 14 “TEMPORARY RULE FOR CERTAIN YEARS.—

15 “(i) BEFORE 2026.—In the case of”,
 16 and

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

18 “(ii) 2026.—In the case of a taxable
 19 year beginning after December 31, 2025,

1 and before January 1, 2027, subparagraph
 2 (A) shall be applied by substituting ‘but
 3 does not exceed 1000 percent’ for ‘but does
 4 not exceed 400 percent’.”.

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

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

9 (a) REDUCTION OF FRAUDULENT ENROLLMENT IN
 10 QUALIFIED HEALTH PLANS.—

11 (1) PENALTIES FOR AGENTS AND BROKERS.—

12 Section 1411(h)(1) of the Patient Protection and Af-
 13 fordable Care Act (42 U.S.C. 18081(h)(1)) is
 14 amended—

15 (A) in subparagraph (A)—

16 (i) by redesignating clause (ii) as
 17 clause (iv);

18 (ii) in clause (i)—

19 (I) in the matter preceding sub-
 20 clause (I), by striking “If—” and all
 21 that follows through the “such per-
 22 son” in the matter following subclause
 23 (II) and inserting the following: “If
 24 any person (other than an agent or
 25 broker) fails to provide correct infor-

1 mation under subsection (b) and such
2 failure is attributable to negligence or
3 disregard of any rules or regulations
4 of the Secretary, such person”; and

5 (II) in the second sentence, by
6 striking “For purposes” and inserting
7 the following:

8 “(iii) DEFINITIONS OF NEGLIGENCE,
9 DISREGARD.—For purposes”;

10 (iii) by inserting after clause (i) the
11 following:

12 “(ii) CIVIL PENALTIES FOR CERTAIN
13 VIOLATIONS BY AGENTS OR BROKERS.—If
14 any agent or broker fails to provide correct
15 information under subsection (b) or section
16 1311(c)(8) or other information, as speci-
17 fied by the Secretary, and such failure is
18 attributable to negligence or disregard of
19 any rules or regulations of the Secretary,
20 such agent or broker shall be subject, in
21 addition to any other penalties that may be
22 prescribed by law, including subparagraph
23 (C), to a civil penalty of not less than
24 \$10,000 and not more than \$50,000 with
25 respect to each individual who is the sub-

ject of an application for which such incorrect information is provided.”; and

(iv) in clause (iv) (as so redesignated), by inserting “or (ii)” after “clause (i)”; (B) in subparagraph (B)—

(i) by inserting “including subparagraph (C),” after “law,”;

(ii) by striking “Any person” and inserting the following:

“(i) IN GENERAL.—Any person”; and (iii) by adding at the end the following:

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

“(I) IN GENERAL.—Any agent or broker who knowingly provides false or fraudulent information under subsection (b) or section 1311(c)(8), or other false or fraudulent information as part of an application for enrollment in a qualified health plan offered through an Exchange, as specified by the Secretary, shall be subject, in addition to any other penalties that may be prescribed by law, including sub-

1 paragraph (C), to a civil penalty of
2 not more than \$200,000 with respect
3 to each individual who is the subject
4 of an application for which such false
5 or fraudulent information is provided.

6 “(II) PROCEDURE.—The provi-
7 sions of section 1128A of the Social
8 Security Act (other than subsections
9 (a) and (b) of such section) shall
10 apply to a civil monetary penalty
11 under subclause (I) in the same man-
12 ner as such provisions apply to a pen-
13 alty or proceeding under section
14 1128A of the Social Security Act.”;
15 and

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

17 “(C) CRIMINAL PENALTIES.—Any agent or
18 broker who knowingly and willfully provides
19 false or fraudulent information under sub-
20 section (b) or section 1311(c)(8), or other false
21 or fraudulent information as part of an applica-
22 tion for enrollment in a qualified health plan of-
23 fered through an Exchange, as specified by the
24 Secretary, shall be fined under title 18, United

1 States Code, imprisoned for not more than 10
2 years, or both.”.

3 (2) CONSUMER PROTECTIONS.—

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

8 “(8) AGENT- OR BROKER-ASSISTED ENROLL-
9 MENT IN QUALIFIED HEALTH PLANS IN CERTAIN
10 EXCHANGES.—

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

1 “(B) REQUIREMENTS.—The enrollment
2 verification process under subparagraph (A)
3 shall include—

4 “(i) a requirement that the agent or
5 broker provide with the new enrollment or
6 coverage change such documentation or
7 evidence (such as a standardized consent
8 form) or other sources as the Secretary de-
9 termines necessary to establish that the
10 agent or broker has the consent of the in-
11 dividual for the new enrollment or coverage
12 change;

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

19 “(iii) a requirement that the informa-
20 tion required under clause (i) and, as ap-
21 plicable, the date on which inconsistencies
22 are resolved as described in clause (ii), is
23 accessible to the applicable qualified health
24 plan through a database or other resource,
25 as determined by the Secretary, so that

1 any commissions due to a broker or agent
2 for such enrollment can be effectuated at
3 the appropriate time;

4 “(iv) a requirement that individuals
5 are notified of any changes to enrollment,
6 coverage, the agent of record, or premium
7 tax credits in a timely manner and that
8 such notice provides plain language in-
9 structions on how individuals can cancel
10 unauthorized activity;

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

23 “(vi) a requirement that the agent or
24 broker report to the Secretary any third-
25 party marketing organization or field mar-

1 keting organization (as such terms are de-
2 fined in section 1312(e)) involved in the
3 chain of enrollment (as so defined) with re-
4 spect to such new enrollment or coverage
5 change.

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

16 (B) REQUIRED REPORTING.—Section
17 1311(c)(1) of the Patient Protection and Af-
18 fordable Care Act (42 U.S.C. 18031(c)(1)) is
19 amended—

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

22 (ii) in subparagraph (I), by striking
23 the period at the end and inserting “;
24 and”; and

1 (iii) by adding at the end the fol-
 2 lowing:

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

6 (3) AUTHORITY TO REGULATE FIELD MAR-
 7 KETING ORGANIZATIONS AND THIRD-PARTY MAR-
 8 KETING ORGANIZATIONS.—Section 1312(e) of the
 9 Patient Protection and Affordable Care Act (42
 10 U.S.C. 18032(e)) is amended—

11 (A) by redesignating paragraphs (1) and
 12 (2) as subclauses (I) and (II), respectively, and
 13 adjusting the margins accordingly;

14 (B) in subclause (II) (as so redesignated),
 15 by striking the period at the end and inserting
 16 “; and”;

17 (C) by striking the subsection designation
 18 and heading and all that follows through “bro-
 19 kers—” and inserting the following:

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

22 “(1) AGENTS, BROKERS, AND CERTAIN MAR-
 23 KETING ORGANIZATIONS.—

1 “(A) IN GENERAL.—The Secretary shall
2 establish procedures under which a State may
3 allow—

4 “(i) agents or brokers—”; and

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

6 “(ii) field marketing organizations
7 and third-party marketing organizations to
8 participate in the chain of enrollment for
9 an individual with respect to qualified
10 health plans offered through an Exchange.

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

1 “(i) an agent or broker act in accord-
2 ance with a standard of conduct that in-
3 cludes a duty of such agent or broker to
4 act in the best interests of the enrollee;

5 “(ii) a field marketing organization or
6 third-party marketing organization agree
7 to report the termination of an agent or
8 broker to the applicable State and the Sec-
9 retary, including the reason for termi-
10 nation; and

11 “(iii) an agent, broker, field mar-
12 keting organization, or third-party mar-
13 keting organization—

14 “(I) meet such marketing re-
15 quirements as are required by the
16 Secretary;

17 “(II) meet marketing require-
18 ments in accordance with other appli-
19 cable Federal or State law;

20 “(III) does not employ practices
21 that are confusing or misleading, as
22 determined by the Secretary;

23 “(IV) submit all marketing mate-
24 rials to the Secretary for, as deter-

1 mined appropriate by the Secretary,
2 review and approval;

3 “(V) is a licensed agent or broker
4 or meets other licensure requirements,
5 as required by the State;

6 “(VI) register with the Secretary;
7 and

8 “(VII) does not compensate any
9 individual or organization for referrals
10 or any other service relating to the
11 sale of, marketing for, or enrollment
12 in qualified health plans unless such
13 individual or organization meets the
14 criteria described in subclauses (I)
15 through (VI).

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

17 “(i) CHAIN OF ENROLLMENT.—The
18 term ‘chain of enrollment’, with respect to
19 enrollment of an individual in a qualified
20 health plan offered through an Exchange,
21 means any steps taken from marketing to
22 such individual, to such individual making
23 an enrollment decision with respect to such
24 a plan.

1 “(ii) FIELD MARKETING ORGANIZA-
2 TION.—The term ‘field marketing organi-
3 zation’ means an organization or individual
4 that directly employs or contracts with
5 agents and brokers, or contracts with car-
6 riers, to provide functions relating to en-
7 rollment of individuals in qualified health
8 plans offered through an Exchange as part
9 of the chain of enrollment.

10 “(iii) MARKETING.—The term ‘mar-
11 keting’ means the use of marketing mate-
12 rials to provide information to current and
13 prospective enrollees in a qualified health
14 plan offered through an Exchange.

15 “(iv) MARKETING MATERIALS.—The
16 term ‘marketing materials’ means mate-
17 rials relating to a qualified health plan of-
18 fered through an Exchange or benefits of-
19 fered through an Exchange that—

20 “(I) are intended—

21 “(aa) to draw an individual’s
22 attention to such plan or the pre-
23 mium tax credits or cost-sharing
24 reductions for such plan or plans
25 offered through an Exchange;

1 “(bb) to influence an indi-
2 vidual’s decision-making process
3 when selecting a qualified health
4 plan in which to enroll; or

5 “(cc) to influence an enroll-
6 ee’s decision to stay enrolled in
7 such plan; and

8 “(II) include or address content
9 regarding the benefits, benefit struc-
10 ture, premiums, or cost sharing of
11 such plan.

12 “(v) TERMINATION.—The term ‘ter-
13 mination’, with respect to a contract or
14 business arrangement between an agent or
15 broker and a field marketing organization,
16 third-party marketing organization, or
17 health insurance issuer, means—

18 “(I) the ending of such contract
19 or business arrangement, either uni-
20 laterally by one of the parties or on
21 mutual agreement; or

22 “(II) the expiration of such con-
23 tract or business arrangement that is
24 not replaced by a substantially similar
25 agreement.

1 “(vi) THIRD-PARTY MARKETING ORGA-
 2 NIZATION.—The term ‘third-party mar-
 3 keting organization’ means an organization
 4 or individual that is compensated to per-
 5 form lead generation, marketing, or sales
 6 relating to enrollment of individuals in
 7 qualified health plans offered through an
 8 Exchange as part of the chain of enroll-
 9 ment.”.

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

15 “(2) AUDITS.—

16 “(A) IN GENERAL.—For plan years begin-
 17 ning on or after such date specified by the Sec-
 18 retary, but not later than January 1, 2029, the
 19 Secretary, in coordination with the States and
 20 in consultation with the National Association of
 21 Insurance Commissioners, shall implement a
 22 process for the oversight and enforcement of
 23 agent and broker compliance with this section
 24 and other applicable Federal and State law (in-
 25 cluding regulations) that shall include—

1 “(i) periodic audits of agents and bro-
2 kers based on—

3 “(I) complaints filed with the
4 Secretary by individuals enrolled by
5 such an agent or broker in a qualified
6 health plan offered through an Ex-
7 change;

8 “(II) an incident or enrollment
9 pattern that suggests fraud; and

10 “(III) other factors determined
11 by the Secretary; and

12 “(ii) a process under which the Sec-
13 retary shall share audit results and refer
14 potential cases of fraud to the relevant
15 State department of insurance.

16 “(B) EFFECT.—Nothing in this paragraph
17 limits or restricts any referrals made under sec-
18 tion 1311(i)(3) or any enforcement actions
19 under section 1411(h).

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

24 (b) REMOVAL OF DECEASED INDIVIDUALS FROM EX-
25 CHANGE PLANS.—Section 1311(c) of the Patient Protec-

1 tion and Affordable Care Act (42 U.S.C. 18031(c)), as
2 amended by subsection (a), is further amended by adding
3 at the end the following new paragraph:

4 “(9) REMOVAL OF DECEASED INDIVIDUALS
5 FROM EXCHANGE PLANS.—

6 “(A) IN GENERAL.—Not later than 90
7 days after the date of the enactment of this
8 paragraph, and on a quarterly basis thereafter,
9 the Secretary shall conduct a check of the
10 Death Master File (as such term is defined in
11 section 203(d) of the Bipartisan Budget Act of
12 2013) for purposes of identifying individuals
13 enrolled in a qualified health plan through an
14 Exchange who are deceased.

15 “(B) PROCESS.—The Secretary shall—

16 “(i) establish a process to verify that
17 an individual identified pursuant to a
18 check described in subparagraph (A) is de-
19 ceased; and

20 “(ii) require an Exchange to termi-
21 nate such individual’s enrollment under a
22 qualified health plan.”.

23 (c) STANDARD OF PROOF FOR TERMINATING
24 AGENTS AND BROKERS.—Section 1312(e) of the Patient
25 Protection and Affordable Care Act (42 U.S.C. 18032(e)),

1 as amended by subsection (a), is further amended by add-
 2 ing at the end the following new paragraph:

3 “(4) STANDARD FOR TERMINATION FOR CER-
 4 TAIN EXCHANGES.—In the case of an agent or
 5 broker with an agreement in effect with an Ex-
 6 change operated by the Secretary pursuant to sec-
 7 tion 1321(c) to perform activities described in para-
 8 graph (1)(A)(i) with respect to such Exchange, the
 9 Secretary may terminate such agreement if the Sec-
 10 retary finds, based on a preponderance of the evi-
 11 dence, that such agent or broker has violated such
 12 agreement, otherwise applicable law, or any other re-
 13 quirement applicable to such agent or broker.”.

14 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIV-
 15 IDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section
 16 1412(c)(2) of the Patient Protection and Affordable Care
 17 Act (42 U.S.C. 18082(c)(2)) is amended by adding at the
 18 end the following new subparagraph:

19 “(C) EXCHANGE RESPONSIBILITIES.—Be-
 20 ginning January 1, 2027, if an Exchange is no-
 21 tified under paragraph (1) of an advance deter-
 22 mination under section 1411 with respect to the
 23 eligibility of an individual for a premium tax
 24 credit under section 36B of the Internal Rev-
 25 enue Code of 1986, the Exchange shall, prior to

1 enrolling such individual in a qualified health
2 plan, clearly notify such individual of the
3 amount of such tax credit.”.

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

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall revise section 155.410(e) of title 45,
8 Code of Federal Regulations (or any successor regulation)
9 to provide that the annual open enrollment period deter-
10 mined for plan year 2026 pursuant to section 1311(c)(6)
11 of the Patient Protection and Affordable Care Act (42
12 U.S.C. 18031(c)(6)) shall begin on November 1, 2025,
13 and end on March 19, 2026.

14 (b) NOTIFICATION OF OPEN ENROLLMENT EXTEN-
15 SION.—The Secretary of Health and Human Services
16 shall perform such outreach activities as are necessary to
17 inform qualified individuals (as defined in section
18 1312(f)(1) of the Patient Protection and Affordable Care
19 Act (42 U.S.C. 18032(f)(1))) of the extended open enroll-
20 ment period provided for under subsection (a).

21 **SEC. 5. MODERNIZING AND ENSURING PBM ACCOUNT-**
22 **ABILITY.**

23 (a) IN GENERAL.—

24 (1) PRESCRIPTION DRUG PLANS.—Section
25 1860D–12 of the Social Security Act (42 U.S.C.

1 1395w–112) is amended by adding at the end the
2 following new subsection:

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

6 “(1) AGREEMENTS WITH PHARMACY BENEFIT
7 MANAGERS.—Each contract entered into with a
8 PDP sponsor under this part with respect to a pre-
9 scription drug plan offered by such sponsor shall
10 provide that any pharmacy benefit manager acting
11 on behalf of such sponsor has a written agreement
12 with the PDP sponsor under which the pharmacy
13 benefit manager, and any affiliates of such phar-
14 macy benefit manager, as applicable, agree to meet
15 the following requirements:

16 “(A) NO INCOME OTHER THAN BONA FIDE
17 SERVICE FEES.—

18 “(i) IN GENERAL.—The pharmacy
19 benefit manager and any affiliate of such
20 pharmacy benefit manager shall not derive
21 any remuneration with respect to any serv-
22 ices provided on behalf of any entity or in-
23 dividual, in connection with the utilization
24 of covered part D drugs, from any such en-

1 tity or individual other than bona fide serv-
2 ice fees, subject to clauses (ii) and (iii).

3 “(ii) INCENTIVE PAYMENTS.—For the
4 purposes of this subsection, an incentive
5 payment (as determined by the Secretary)
6 paid by a PDP sponsor to a pharmacy
7 benefit manager that is performing serv-
8 ices on behalf of such sponsor shall be
9 deemed a ‘bona fide service fee’ (even if
10 such payment does not otherwise meet the
11 definition of such term under paragraph
12 (7)(B)) if such payment is a flat dollar
13 amount, is consistent with fair market
14 value (as specified by the Secretary), is re-
15 lated to services actually performed by the
16 pharmacy benefit manager or affiliate of
17 such pharmacy benefit manager, on behalf
18 of the PDP sponsor making such payment,
19 in connection with the utilization of cov-
20 ered part D drugs, and meets additional
21 requirements, if any, as determined appro-
22 priate by the Secretary.

23 “(iii) CLARIFICATION ON REBATES
24 AND DISCOUNTS USED TO LOWER COSTS
25 FOR COVERED PART D DRUGS.—Rebates,

1 discounts, and other price concessions re-
2 ceived by a pharmacy benefit manager or
3 an affiliate of a pharmacy benefit manager
4 from manufacturers, even if such price
5 concessions are calculated as a percentage
6 of a drug's price, shall not be considered a
7 violation of the requirements of clause (i)
8 if they are fully passed through to a PDP
9 sponsor and are compliant with all regu-
10 latory and subregulatory requirements re-
11 lated to direct and indirect remuneration
12 for manufacturer rebates under this part,
13 including in cases where a PDP sponsor is
14 acting as a pharmacy benefit manager on
15 behalf of a prescription drug plan offered
16 by such PDP sponsor.

17 “(iv) EVALUATION OF REMUNERATION
18 ARRANGEMENTS.—Components of subsets
19 of remuneration arrangements (such as
20 fees or other forms of compensation paid
21 to or retained by the pharmacy benefit
22 manager or affiliate of such pharmacy ben-
23 efit manager), as determined appropriate
24 by the Secretary, between pharmacy ben-
25 efit managers or affiliates of such phar-

1 macy benefit managers, as applicable, and
2 other entities involved in the dispensing or
3 utilization of covered part D drugs (includ-
4 ing PDP sponsors, manufacturers, phar-
5 macies, and other entities as determined
6 appropriate by the Secretary) shall be sub-
7 ject to review by the Secretary, in con-
8 sultation with the Office of the Inspector
9 General of the Department of Health and
10 Human Services, as determined appro-
11 priate by the Secretary. The Secretary, in
12 consultation with the Office of the Inspec-
13 tor General, shall review whether remu-
14 nation under such arrangements is con-
15 sistent with fair market value (as specified
16 by the Secretary) through reviews and as-
17 sessments of such remuneration, as deter-
18 mined appropriate.

19 “(v) DISGORGEMENT.—The pharmacy
20 benefit manager shall disgorge any remu-
21 nation paid to such pharmacy benefit
22 manager or an affiliate of such pharmacy
23 benefit manager in violation of this sub-
24 paragraph to the PDP sponsor.

1 “(vi) ADDITIONAL REQUIREMENTS.—

2 The pharmacy benefit manager shall—

3 “(I) enter into a written agree-
4 ment with any affiliate of such phar-
5 macy benefit manager, under which
6 the affiliate shall identify and disgorge
7 any remuneration described in clause
8 (v) to the pharmacy benefit manager;
9 and

10 “(II) attest, subject to any re-
11 quirements determined appropriate by
12 the Secretary, that the pharmacy ben-
13 efit manager has entered into a writ-
14 ten agreement described in subclause
15 (I) with any relevant affiliate of the
16 pharmacy benefit manager.

17 “(B) TRANSPARENCY REGARDING GUARAN-
18 TEES AND COST PERFORMANCE EVALUA-
19 TIONS.—The pharmacy benefit manager shall—

20 “(i) define, interpret, and apply, in a
21 fully transparent and consistent manner
22 for purposes of calculating or otherwise
23 evaluating pharmacy benefit manager per-
24 formance against pricing guarantees or
25 similar cost performance measurements re-

lated to rebates, discounts, price concessions, or net costs, terms such as—

“(I) ‘generic drug’, in a manner consistent with the definition of the term under section 423.4 of title 42, Code of Federal Regulations, or a successor regulation;

“(II) ‘brand name drug’, in a manner consistent with the definition of the term under section 423.4 of title 42, Code of Federal Regulations, or a successor regulation;

“(III) ‘specialty drug’;

“(IV) ‘rebate’; and

“(V) ‘discount’;

“(ii) identify any drugs, claims, or price concessions excluded from any pricing guarantee or other cost performance measure in a clear and consistent manner; and

“(iii) where a pricing guarantee or other cost performance measure is based on a pricing benchmark other than the wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) of a drug, cal-

1 culate and provide a wholesale acquisition
2 cost-based equivalent to the pricing guar-
3 antee or other cost performance measure.

4 “(C) PROVISION OF INFORMATION.—

5 “(i) IN GENERAL.—Not later than
6 July 1 of each year, beginning in 2029, the
7 pharmacy benefit manager shall submit to
8 the PDP sponsor, and to the Secretary, a
9 report, in accordance with this subpara-
10 graph, and shall make such report avail-
11 able to such sponsor at no cost to such
12 sponsor in a format specified by the Sec-
13 retary under paragraph (5). Each such re-
14 port shall include, with respect to such
15 PDP sponsor and each plan offered by
16 such sponsor, the following information
17 with respect to the previous plan year:

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

21 “(aa) the brand name, ge-
22 neric or non-proprietary name,
23 and National Drug Code;

24 “(bb) the number of plan
25 enrollees for whom the drug was

1 dispensed, the total number of
2 prescription claims for the drug
3 (including original prescriptions
4 and refills, counted as separate
5 claims), and the total number of
6 dosage units of the drug dis-
7 pensed;

8 “(cc) the number of pre-
9 scription claims described in item
10 (bb) by each type of dispensing
11 channel through which the drug
12 was dispensed, including retail,
13 mail order, specialty pharmacy,
14 long term care pharmacy, home
15 infusion pharmacy, or other types
16 of pharmacies or providers;

17 “(dd) the average wholesale
18 acquisition cost, listed as cost per
19 day’s supply, cost per dosage
20 unit, and cost per typical course
21 of treatment (as applicable);

22 “(ee) the average wholesale
23 price for the drug, listed as price
24 per day’s supply, price per dos-
25 age unit, and price per typical

1 course of treatment (as applica-
2 ble);

3 “(ff) the total out-of-pocket
4 spending by plan enrollees on
5 such drug after application of
6 any benefits under the plan, in-
7 cluding plan enrollee spending
8 through copayments, coinsurance,
9 and deductibles;

10 “(gg) total rebates paid by
11 the manufacturer on the drug as
12 reported under the Detailed DIR
13 Report (or any successor report)
14 submitted by such sponsor to the
15 Centers for Medicare & Medicaid
16 Services;

17 “(hh) all other direct or in-
18 direct remuneration on the drug
19 as reported under the Detailed
20 DIR Report (or any successor re-
21 port) submitted by such sponsor
22 to the Centers for Medicare &
23 Medicaid Services;

24 “(ii) the average pharmacy
25 reimbursement amount paid by

1 the plan for the drug in the ag-
2 gregate and disaggregated by dis-
3 pensing channel identified in item
4 (cc);

5 “(jj) the average National
6 Average Drug Acquisition Cost
7 (NADAC); and

8 “(kk) total manufacturer-de-
9 rived revenue, inclusive of bona
10 fide service fees, attributable to
11 the drug and retained by the
12 pharmacy benefit manager and
13 any affiliate of such pharmacy
14 benefit manager.

15 “(II) In the case of a pharmacy
16 benefit manager that has an affiliate
17 that is a retail, mail order, or spe-
18 cialty pharmacy, with respect to drugs
19 covered by such plan that were dis-
20 pensed, the following information:

21 “(aa) The percentage of
22 total prescriptions that were dis-
23 pensed by pharmacies that are an
24 affiliate of the pharmacy benefit
25 manager for each drug.

1 “(bb) The interquartile
2 range of the total combined costs
3 paid by the plan and plan enroll-
4 ees, per dosage unit, per course
5 of treatment, per 30-day supply,
6 and per 90-day supply for each
7 drug dispensed by pharmacies
8 that are not an affiliate of the
9 pharmacy benefit manager and
10 that are included in the phar-
11 macy network of such plan.

12 “(cc) The interquartile
13 range of the total combined costs
14 paid by the plan and plan enroll-
15 ees, per dosage unit, per course
16 of treatment, per 30-day supply,
17 and per 90-day supply for each
18 drug dispensed by pharmacies
19 that are an affiliate of the phar-
20 macy benefit manager and that
21 are included in the pharmacy
22 network of such plan.

23 “(dd) The lowest total com-
24 bined cost paid by the plan and
25 plan enrollees, per dosage unit,

1 per course of treatment, per 30-
2 day supply, and per 90-day sup-
3 ply, for each drug that is avail-
4 able from any pharmacy included
5 in the pharmacy network of such
6 plan.

7 “(ee) The difference between
8 the average acquisition cost of
9 the affiliate, such as a pharmacy
10 or other entity that acquires pre-
11 scription drugs, that initially ac-
12 quires the drug and the amount
13 reported under subclause (I)(jj)
14 for each drug.

15 “(ff) A list inclusive of the
16 brand name, generic or non-pro-
17 prietary name, and National
18 Drug Code of covered part D
19 drugs subject to an agreement
20 with a covered entity under sec-
21 tion 340B of the Public Health
22 Service Act for which the phar-
23 macy benefit manager or an affil-
24 iate of the pharmacy benefit
25 manager had a contract or other

1 arrangement with such a covered
2 entity in the service area of such
3 plan.

4 “(III) Where a drug approved
5 under section 505(c) of the Federal
6 Food, Drug, and Cosmetic Act (re-
7 ferred to in this subclause as the ‘list-
8 ed drug’) is covered by the plan, the
9 following information:

10 “(aa) A list of currently
11 marketed generic drugs approved
12 under section 505(j) of the Fed-
13 eral Food, Drug, and Cosmetic
14 Act pursuant to an application
15 that references such listed drug
16 that are not covered by the plan,
17 are covered on the same for-
18 mulary tier or a formulary tier
19 typically associated with higher
20 cost-sharing than the listed drug,
21 or are subject to utilization man-
22 agement that the listed drug is
23 not subject to.

24 “(bb) The estimated average
25 beneficiary cost-sharing under

1 the plan for a 30-day supply of
2 the listed drug.

3 “(cc) Where a generic drug
4 listed under item (aa) is on a for-
5 mulary tier typically associated
6 with higher cost-sharing than the
7 listed drug, the estimated aver-
8 age cost-sharing that a bene-
9 ficiary would have paid for a 30-
10 day supply of each of the generic
11 drugs described in item (aa), had
12 the plan provided coverage for
13 such drugs on the same for-
14 mulary tier as the listed drug.

15 “(dd) A written justification
16 for providing more favorable cov-
17 erage of the listed drug than the
18 generic drugs described in item
19 (aa).

20 “(ee) The number of cur-
21 rently marketed generic drugs
22 approved under section 505(j) of
23 the Federal Food, Drug, and
24 Cosmetic Act pursuant to an ap-

1 plication that references such
2 listed drug.

3 “(IV) Where a reference product
4 (as defined in section 351(i) of the
5 Public Health Service Act) is covered
6 by the plan, the following information:

7 “(aa) A list of currently
8 marketed biosimilar biological
9 products licensed under section
10 351(k) of the Public Health
11 Service Act pursuant to an appli-
12 cation that refers to such ref-
13 erence product that are not cov-
14 ered by the plan, are covered on
15 the same formulary tier or a for-
16 mulary tier typically associated
17 with higher cost-sharing than the
18 reference product, or are subject
19 to utilization management that
20 the reference product is not sub-
21 ject to.

22 “(bb) The estimated average
23 beneficiary cost-sharing under
24 the plan for a 30-day supply of
25 the reference product.

1 “(cc) Where a biosimilar bi-
2 ological product listed under item
3 (aa) is on a formulary tier typi-
4 cally associated with higher cost-
5 sharing than the reference prod-
6 uct, the estimated average cost-
7 sharing that a beneficiary would
8 have paid for a 30-day supply of
9 each of the biosimilar biological
10 products described in item (aa),
11 had the plan provided coverage
12 for such products on the same
13 formulary tier as the reference
14 product.

15 “(dd) A written justification
16 for providing more favorable cov-
17 erage of the reference product
18 than the biosimilar biological
19 product described in item (aa).

20 “(ee) The number of cur-
21 rently marketed biosimilar bio-
22 logical products licensed under
23 section 351(k) of the Public
24 Health Service Act, pursuant to

1 an application that refers to such
2 reference product.

3 “(V) Total gross spending on
4 covered part D drugs by the plan, not
5 net of rebates, fees, discounts, or
6 other direct or indirect remuneration.

7 “(VI) The total amount retained
8 by the pharmacy benefit manager or
9 an affiliate of such pharmacy benefit
10 manager in revenue related to utiliza-
11 tion of covered part D drugs under
12 that plan, inclusive of bona fide serv-
13 ice fees.

14 “(VII) The total spending on cov-
15 ered part D drugs net of rebates, fees,
16 discounts, or other direct and indirect
17 remuneration by the plan.

18 “(VIII) An explanation of any
19 benefit design parameters under such
20 plan that encourage plan enrollees to
21 fill prescriptions at pharmacies that
22 are an affiliate of such pharmacy ben-
23 efit manager, such as mail and spe-
24 cialty home delivery programs, and re-
25 tail and mail auto-refill programs.

1 “(IX) The following information:

2 “(aa) A list of all brokers,
3 consultants, advisors, and audi-
4 tors that receive compensation
5 from the pharmacy benefit man-
6 ager or an affiliate of such phar-
7 macy benefit manager for refer-
8 rals, consulting, auditing, or
9 other services offered to PDP
10 sponsors related to pharmacy
11 benefit management services.

12 “(bb) The amount of com-
13 pensation provided by such phar-
14 macy benefit manager or affiliate
15 to each such broker, consultant,
16 advisor, and auditor.

17 “(cc) The methodology for
18 calculating the amount of com-
19 pensation provided by such phar-
20 macy benefit manager or affil-
21 iate, for each such broker, con-
22 sultant, advisor, and auditor.

23 “(X) A list of all affiliates of the
24 pharmacy benefit manager.

1 “(XI) A summary document sub-
2 mitted in a standardized template de-
3 veloped by the Secretary that includes
4 such information described in sub-
5 clauses (I) through (X).

6 “(ii) WRITTEN EXPLANATION OF CON-
7 TRACTS OR AGREEMENTS WITH DRUG
8 MANUFACTURERS.—

9 “(I) IN GENERAL.—The phar-
10 macy benefit manager shall, not later
11 than 30 days after the finalization of
12 any contract or agreement between
13 such pharmacy benefit manager or an
14 affiliate of such pharmacy benefit
15 manager and a drug manufacturer (or
16 subsidiary, agent, or entity affiliated
17 with such drug manufacturer) that
18 makes rebates, discounts, payments,
19 or other financial incentives related to
20 one or more covered part D drugs or
21 other prescription drugs, as applica-
22 ble, of the manufacturer directly or
23 indirectly contingent upon coverage,
24 formulary placement, or utilization
25 management conditions on any other

1 covered part D drugs or other pre-
2 scription drugs, as applicable, submit
3 to the PDP sponsor a written expla-
4 nation of such contract or agreement.

5 “(II) REQUIREMENTS.—A writ-
6 ten explanation under subclause (I)
7 shall—

8 “(aa) include the manufac-
9 turer subject to the contract or
10 agreement, all covered part D
11 drugs and other prescription
12 drugs, as applicable, subject to
13 the contract or agreement and
14 the manufacturers of such drugs,
15 and a high-level description of
16 the terms of such contract or
17 agreement and how such terms
18 apply to such drugs; and

19 “(bb) be certified by the
20 Chief Executive Officer, Chief Fi-
21 nancial Officer, or General Coun-
22 sel of such pharmacy benefit
23 manager, or affiliate of such
24 pharmacy benefit manager, as
25 applicable, or an individual dele-

1 gated with the authority to sign
2 on behalf of one of these officers,
3 who reports directly to the offi-
4 cer.

5 “(III) DEFINITION OF OTHER
6 PRESCRIPTION DRUGS.—For purposes
7 of this clause, the term ‘other pre-
8 scription drugs’ means prescription
9 drugs covered as supplemental bene-
10 fits under this part or prescription
11 drugs paid outside of this part.

12 “(D) AUDIT RIGHTS.—

13 “(i) IN GENERAL.—Not less than once
14 a year, at the request of the PDP sponsor,
15 the pharmacy benefit manager shall allow
16 for an audit of the pharmacy benefit man-
17 ager to ensure compliance with all terms
18 and conditions under the written agree-
19 ment described in this paragraph and the
20 accuracy of information reported under
21 subparagraph (C).

22 “(ii) AUDITOR.—The PDP sponsor
23 shall have the right to select an auditor.
24 The pharmacy benefit manager shall not

1 impose any limitations on the selection of
2 such auditor.

3 “(iii) PROVISION OF INFORMATION.—

4 The pharmacy benefit manager shall make
5 available to such auditor all records, data,
6 contracts, and other information necessary
7 to confirm the accuracy of information
8 provided under subparagraph (C), subject
9 to reasonable restrictions on how such in-
10 formation must be reported to prevent re-
11 disclosure of such information.

12 “(iv) TIMING.—The pharmacy benefit

13 manager must provide information under
14 clause (iii) and other information, data,
15 and records relevant to the audit to such
16 auditor within 6 months of the initiation of
17 the audit and respond to requests for addi-
18 tional information from such auditor with-
19 in 30 days after the request for additional
20 information.

21 “(v) INFORMATION FROM AFFILI-

22 ATES.—The pharmacy benefit manager
23 shall be responsible for providing to such
24 auditor information required to be reported
25 under subparagraph (C) or under clause

(iii) of this subparagraph that is owned or held by an affiliate of such pharmacy benefit manager.

“(2) ENFORCEMENT.—

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

“(i) disgorge to the Secretary any amounts disgorged to the PDP sponsor by a pharmacy benefit manager under paragraph (1)(A)(v);

“(ii) require, in a written agreement with any pharmacy benefit manager acting on behalf of such sponsor or affiliate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate reimburse the PDP sponsor for any civil money penalty imposed on the PDP sponsor as a result of the failure of the pharmacy benefit manager or affiliate to meet the requirements of paragraph (1) that are applicable to the pharmacy benefit manager or affiliate under the agreement; and

“(iii) require, in a written agreement with any such pharmacy benefit manager acting on behalf of such sponsor or affil-

1 iate of such pharmacy benefit manager,
2 that such pharmacy benefit manager or af-
3 filiate be subject to punitive remedies for
4 breach of contract for failure to comply
5 with the requirements applicable under
6 paragraph (1).

7 “(B) REPORTING OF ALLEGED VIOLA-
8 TIONS.—The Secretary shall make available and
9 maintain a mechanism for manufacturers, PDP
10 sponsors, pharmacies, and other entities that
11 have contractual relationships with pharmacy
12 benefit managers or affiliates of such pharmacy
13 benefit managers to report, on a confidential
14 basis, alleged violations of paragraph (1)(A) or
15 subparagraph (C).

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

19 “(i) retaliate against an individual or
20 entity for reporting an alleged violation
21 under subparagraph (B); or

22 “(ii) coerce, intimidate, threaten, or
23 interfere with the ability of an individual
24 or entity to report any such alleged viola-
25 tions.

1 “(3) CERTIFICATION OF COMPLIANCE.—

2 “(A) IN GENERAL.—Each PDP sponsor
3 shall furnish to the Secretary (at a time and in
4 a manner specified by the Secretary) an annual
5 certification of compliance with this subsection,
6 as well as such information as the Secretary de-
7 termines necessary to carry out this subsection.

8 “(B) IMPLEMENTATION.—Notwithstanding
9 any other provision of law, the Secretary may
10 implement this paragraph by program instruc-
11 tion or otherwise.

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

14 “(A) prohibiting flat dispensing fees or re-
15 imbursement or payment for ingredient costs
16 (including customary, industry-standard dis-
17 counts directly related to drug acquisition that
18 are retained by pharmacies or wholesalers) to
19 entities that acquire or dispense prescription
20 drugs; or

21 “(B) modifying regulatory requirements or
22 sub-regulatory program instruction or guidance
23 related to pharmacy payment, reimbursement,
24 or dispensing fees.

25 “(5) STANDARD FORMATS.—

1 “(A) IN GENERAL.—Not later than June
2 1, 2028, the Secretary shall specify standard,
3 machine-readable formats for pharmacy benefit
4 managers to submit annual reports required
5 under paragraph (1)(C)(i).

6 “(B) IMPLEMENTATION.—Notwithstanding
7 any other provision of law, the Secretary may
8 implement this paragraph by program instruc-
9 tion or otherwise.

10 “(6) CONFIDENTIALITY.—

11 “(A) IN GENERAL.—Information disclosed
12 by a pharmacy benefit manager, an affiliate of
13 a pharmacy benefit manager, a PDP sponsor,
14 or a pharmacy under this subsection that is not
15 otherwise publicly available or available for pur-
16 chase shall not be disclosed by the Secretary or
17 a PDP sponsor receiving the information, ex-
18 cept that the Secretary may disclose the infor-
19 mation for the following purposes:

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

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

1 “(iii) To permit the Director of the
2 Congressional Budget Office to review the
3 information provided.

4 “(iv) To permit the Executive Direc-
5 tor of the Medicare Payment Advisory
6 Commission to review the information pro-
7 vided.

8 “(v) To the Attorney General for the
9 purposes of conducting oversight and en-
10 forcement under this title.

11 “(vi) To the Inspector General of the
12 Department of Health and Human Serv-
13 ices in accordance with its authorities
14 under the Inspector General Act of 1978
15 (section 406 of title 5, United States
16 Code), and other applicable statutes.

17 “(B) RESTRICTION ON USE OF INFORMA-
18 TION.—The Secretary, the Comptroller General,
19 the Director of the Congressional Budget Of-
20 fice, and the Executive Director of the Medicare
21 Payment Advisory Commission shall not report
22 on or disclose information disclosed pursuant to
23 subparagraph (A) to the public in a manner
24 that would identify—

1 “(i) a specific pharmacy benefit man-
2 ager, affiliate, pharmacy, manufacturer,
3 wholesaler, PDP sponsor, or plan; or

4 “(ii) contract prices, rebates, dis-
5 counts, or other remuneration for specific
6 drugs in a manner that may allow the
7 identification of specific contracting parties
8 or of such specific drugs.

9 “(7) DEFINITIONS.—For purposes of this sub-
10 section:

11 “(A) AFFILIATE.—The term ‘affiliate’
12 means, with respect to any pharmacy benefit
13 manager or PDP sponsor, any entity that, di-
14 rectly or indirectly—

15 “(i) owns or is owned by, controls or
16 is controlled by, or is otherwise related in
17 any ownership structure to such pharmacy
18 benefit manager or PDP sponsor; or

19 “(ii) acts as a contractor, principal, or
20 agent to such pharmacy benefit manager
21 or PDP sponsor, insofar as such con-
22 tractor, principal, or agent performs any of
23 the functions described under subpara-
24 graph (C).

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

14 “(i) drug price, such as wholesale ac-
15 quisition cost or drug benchmark price
16 (such as average wholesale price);

17 “(ii) the amount of discounts, rebates,
18 fees, or other direct or indirect remunera-
19 tion with respect to covered part D drugs
20 dispensed to enrollees in a prescription
21 drug plan, except as permitted pursuant to
22 paragraph (1)(A)(ii);

23 “(iii) coverage or formulary placement
24 decisions or the volume or value of any re-

1 ferrals or business generated between the
2 parties to the arrangement; or

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

5 “(C) PHARMACY BENEFIT MANAGER.—The
6 term ‘pharmacy benefit manager’ means any
7 person or entity that, either directly or through
8 an intermediary, acts as a price negotiator or
9 group purchaser on behalf of a PDP sponsor or
10 prescription drug plan, or manages the pre-
11 scription drug benefits provided by such spon-
12 sor or plan, including the processing and pay-
13 ment of claims for prescription drugs, the per-
14 formance of drug utilization review, the proc-
15 essing of drug prior authorization requests, the
16 adjudication of appeals or grievances related to
17 the prescription drug benefit, contracting with
18 network pharmacies, controlling the cost of cov-
19 ered part D drugs, or the provision of related
20 services. Such term includes any person or enti-
21 ty that carries out one or more of the activities
22 described in the preceding sentence, irrespective
23 of whether such person or entity calls itself a
24 ‘pharmacy benefit manager’.”.

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

5 “(F) REQUIREMENTS RELATING TO PHAR-
6 MACY BENEFIT MANAGERS.—For plan years be-
7 ginning on or after January 1, 2029, section
8 1860D–12(h).”.

9 (3) NONAPPLICATION OF PAPERWORK REDUC-
10 TION ACT.—Chapter 35 of title 44, United States
11 Code, shall not apply to the implementation of this
12 subsection.

13 (4) FUNDING.—

14 (A) SECRETARY.—In addition to amounts
15 otherwise available, there is appropriated to the
16 Centers for Medicare & Medicaid Services Pro-
17 gram Management Account, out of any money
18 in the Treasury not otherwise appropriated,
19 \$113,000,000 for fiscal year 2026, to remain
20 available until expended, to carry out this sub-
21 section.

22 (B) OIG.—In addition to amounts other-
23 wise available, there is appropriated to the In-
24 specter General of the Department of Health
25 and Human Services, out of any money in the

1 Treasury not otherwise appropriated,
2 \$20,000,000 for fiscal year 2026, to remain
3 available until expended, to carry out this sub-
4 section.

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

7 (1) STUDY.—The Comptroller General of the
8 United States (in this subsection referred to as the
9 “Comptroller General”) shall conduct a study de-
10 scribing the use of compensation and payment struc-
11 tures related to a prescription drug’s price within
12 the retail prescription drug supply chain in part D
13 of title XVIII of the Social Security Act (42 U.S.C.
14 1395w–101 et seq.). Such study shall summarize in-
15 formation from Federal agencies and industry ex-
16 perts, to the extent available, with respect to the fol-
17 lowing:

18 (A) The type, magnitude, other features
19 (such as the pricing benchmarks used), and
20 prevalence of compensation and payment struc-
21 tures related to a prescription drug’s price,
22 such as calculating fee amounts as a percentage
23 of a prescription drug’s price, between inter-
24 mediaries in the prescription drug supply chain,
25 including—

- 1 (i) pharmacy benefit managers;
- 2 (ii) PDP sponsors offering prescrip-
- 3 tion drug plans and Medicare Advantage
- 4 organizations offering MA–PD plans;
- 5 (iii) drug wholesalers;
- 6 (iv) pharmacies;
- 7 (v) manufacturers;
- 8 (vi) pharmacy services administrative
- 9 organizations;
- 10 (vii) brokers, auditors, consultants,
- 11 and other entities that—

12 (I) advise PDP sponsors offering
13 prescription drug plans and Medicare
14 Advantage organizations offering MA–
15 PD plans regarding pharmacy bene-
16 fits; or

17 (II) review PDP sponsor and
18 Medicare Advantage organization con-
19 tracts with pharmacy benefit man-
20 agers; and

21 (viii) other service providers that con-
22 tract with any of the entities described in
23 clauses (i) through (vii) that may use
24 price-related compensation and payment
25 structures, such as rebate aggregators (or

1 other entities that negotiate or process
2 price concessions on behalf of pharmacy
3 benefit managers, plan sponsors, or phar-
4 macies).

5 (B) The primary business models and com-
6 pensation structures for each category of inter-
7 mediary described in subparagraph (A).

8 (C) Variation in price-related compensation
9 structures between affiliated entities (such as
10 entities with common ownership, either full or
11 partial, and subsidiary relationships) and unaf-
12 filiated entities.

13 (D) Potential conflicts of interest among
14 contracting entities related to the use of pre-
15 scription drug price-related compensation struc-
16 tures, such as the potential for fees or other
17 payments set as a percentage of a prescription
18 drug's price to advantage formulary selection,
19 distribution, or purchasing of prescription drugs
20 with higher prices.

21 (E) Notable differences, if any, in the use
22 and level of price-based compensation struc-
23 tures over time and between different market
24 segments, such as under part D of title XVIII
25 of the Social Security Act (42 U.S.C. 1395w–

1 101 et seq.) and the Medicaid program under
2 title XIX of such Act (42 U.S.C. 1396 et seq.).

3 (F) The effects of drug price-related com-
4 pensation structures and alternative compensa-
5 tion structures on Federal health care programs
6 and program beneficiaries, including with re-
7 spect to cost-sharing, premiums, Federal out-
8 lays, biosimilar and generic drug adoption and
9 utilization, drug shortage risks, and the poten-
10 tial for fees set as a percentage of a drug's
11 price to advantage the formulary selection, dis-
12 tribution, or purchasing of drugs with higher
13 prices.

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

16 (2) REPORT.—Not later than 2 years after the
17 date of enactment of this section, the Comptroller
18 General shall submit to Congress a report containing
19 the results of the study conducted under paragraph
20 (1), together with recommendations for such legisla-
21 tion and administrative action as the Comptroller
22 General determines appropriate.

23 (c) MEDPAC REPORTS ON AGREEMENTS WITH
24 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-
25 SCRIPTION DRUG PLANS AND MA–PD PLANS.—

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

4 (A) INITIAL REPORT.—Not later than the
5 first March 15 occurring after the date that is
6 2 years after the date on which the Secretary
7 makes the data available to the Commission, a
8 report regarding agreements with pharmacy
9 benefit managers with respect to prescription
10 drug plans and MA–PD plans. Such report
11 shall include, to the extent practicable—

12 (i) a description of trends and pat-
13 terns, including relevant averages, totals,
14 and other figures for the types of informa-
15 tion submitted;

16 (ii) an analysis of any differences in
17 agreements and their effects on plan en-
18 rollee out-of-pocket spending and average
19 pharmacy reimbursement, and other im-
20 pacts; and

21 (iii) any recommendations the Com-
22 mission determines appropriate.

23 (B) FINAL REPORT.—Not later than 2
24 years after the date on which the Commission
25 submits the initial report under subparagraph

1 (A), a report describing any changes with re-
 2 spect to the information described in subpara-
 3 graph (A) over time, together with any rec-
 4 ommendations the Commission determines ap-
 5 propriate.

6 (2) FUNDING.—In addition to amounts other-
 7 wise available, there is appropriated to the Medicare
 8 Payment Advisory Commission, out of any money in
 9 the Treasury not otherwise appropriated,
 10 \$1,000,000 for fiscal year 2026, to remain available
 11 until expended, to carry out this subsection.

12 **SEC. 6. EXPEDITED CONSIDERATION OF ENHANCED PRE-**
 13 **MIUM TAX CREDIT REFORM BILL.**

14 (a) QUALIFYING LEGISLATION.—

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

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

1 (b) CONSIDERATION IN THE HOUSE OF REPRESENT-
2 ATIVES.—

3 (1) REFERRAL AND REPORTING.—Any com-
4 mittee of the House of Representatives to which an
5 enhanced premium tax credit reform bill is referred
6 shall report the enhanced premium tax credit reform
7 bill to the House of Representatives without amend-
8 ment not later than 5 legislative days after the date
9 on which the enhanced premium tax credit reform
10 bill was so referred. If a committee of the House of
11 Representatives fails to report an enhanced premium
12 tax credit reform bill within that period, that com-
13 mittee shall be automatically discharged from con-
14 sideration of the enhanced premium tax credit re-
15 form bill, and the enhanced premium tax credit re-
16 form bill shall be placed on the appropriate calendar.

17 (2) PROCEEDING TO CONSIDERATION.—After
18 the last committee authorized to consider an en-
19 hanced premium tax credit reform bill reports it to
20 the House of Representatives or has been discharged
21 from its consideration, it shall be in order to move
22 to proceed to consider the enhanced premium tax
23 credit reform bill in the House of Representatives.
24 Such a motion shall not be in order after the House
25 of Representatives has disposed of a motion to pro-

1 ceed with respect to the enhanced premium tax cred-
2 it reform bill. The previous question shall be consid-
3 ered as ordered on the motion to its adoption with-
4 out intervening motion. The motion shall not be de-
5 batable. A motion to reconsider the vote by which
6 the motion is disposed of shall not be in order.

7 (3) VOTE ON PASSAGE.—The vote on passage
8 of the enhanced premium tax credit reform bill shall
9 occur not later than 3 legislative days after the date
10 on which the last committee authorized to consider
11 the enhanced premium tax credit reform bill reports
12 it to the House of Representatives or is discharged.

13 (c) EXPEDITED PROCEDURE IN THE SENATE.—

14 (1) COMMITTEE CONSIDERATION.—An en-
15 hanced premium tax credit reform bill introduced in
16 the Senate shall be jointly referred to the committee
17 or committees of jurisdiction, which committees shall
18 report the enhanced premium tax credit reform bill
19 without any revision and with a favorable rec-
20 ommendation, an unfavorable recommendation, or
21 without recommendation, not later than 5 session
22 days after the date on which the enhanced premium
23 tax credit reform bill was so referred. If any com-
24 mittee to which an enhanced premium tax credit re-
25 form bill is referred fails to report the enhanced pre-

1 mium tax credit reform bill within that period, that
2 committee shall be automatically discharged from
3 consideration of the enhanced premium tax credit re-
4 form bill, and the enhanced premium tax credit re-
5 form bill shall be placed on the appropriate calendar.

6 (2) PROCEEDING.—Notwithstanding rule XXII
7 of the Standing Rules of the Senate, it is in order,
8 not later than 2 days of session after the date on
9 which an enhanced premium tax credit reform bill is
10 reported or discharged from all committees to which
11 the enhanced premium tax credit reform bill was re-
12 ferred, for the majority leader of the Senate or the
13 designee of the majority leader to move to proceed
14 to the consideration of the enhanced premium tax
15 credit reform bill. It shall also be in order for any
16 Member of the Senate to move to proceed to the
17 consideration of the enhanced premium tax credit re-
18 form bill at any time after the conclusion of such 2-
19 day period. A motion to proceed is in order even
20 though a previous motion to the same effect has
21 been disagreed to. All points of order against the
22 motion to proceed to the enhanced premium tax
23 credit reform bill are waived. The motion to proceed
24 is not debatable. The motion is not subject to a mo-
25 tion to postpone. A motion to reconsider the vote by

1 which the motion is agreed to or disagreed to shall
2 not be in order. If a motion to proceed to the consid-
3 eration of the enhanced premium tax credit reform
4 bill is agreed to, the enhanced premium tax credit
5 reform bill shall remain the unfinished business until
6 disposed of. All points of order against an enhanced
7 premium tax credit reform bill and against consider-
8 ation of the enhanced premium tax credit reform bill
9 are waived.

10 (d) CONSIDERATION BY THE OTHER HOUSE.—

11 (1) IN GENERAL.—If, before passing an en-
12 hanced premium tax credit reform bill, a House re-
13 ceives from the other House an enhanced premium
14 tax credit reform bill of the other House—

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

18 (B) the procedure in the receiving House
19 shall be the same as if no enhanced premium
20 tax credit reform bill had been received from
21 the other House until the vote on passage, when
22 the enhanced premium tax credit reform bill re-
23 ceived from the other House shall supplant the
24 enhanced premium tax credit reform bill of the
25 receiving House.

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

5 (e) RULES TO COORDINATE ACTION WITH OTHER
6 HOUSE.—

7 (1) TREATMENT OF ENHANCED PREMIUM TAX
8 CREDIT REFORM BILL OF OTHER HOUSE.—If an en-
9 hanced premium tax credit reform bill is not intro-
10 duced in the Senate or the Senate fails to consider
11 an enhanced premium tax credit reform bill under
12 this section, the enhanced premium tax credit re-
13 form bill of the House of Representatives shall be
14 entitled to expedited floor procedures under this sec-
15 tion.

16 (2) TREATMENT OF COMPANION MEASURES IN
17 THE SENATE.—If, following passage of an enhanced
18 premium tax credit reform bill in the Senate, the
19 Senate then receives from the House of Representa-
20 tives an enhanced premium tax credit reform bill,
21 the House-passed enhanced premium tax credit re-
22 form bill shall not be debatable. The vote on passage
23 of the enhanced premium tax credit reform bill in
24 the Senate shall be considered to be the vote on pas-

1 sage of the enhanced premium tax credit reform bill
2 received from the House of Representatives.

3 (3) VETOES.—If the President vetoes an en-
4 hanced premium tax credit reform bill, consideration
5 of a veto message in the Senate under this para-
6 graph shall be 10 hours equally divided between the
7 majority and minority leaders of the Senate or the
8 designees of the majority and minority leaders of the
9 Senate.

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

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

16 (1) as an exercise of the rulemaking power of
17 the Senate and House of Representatives, respec-
18 tively, and as such it is deemed a part of the rules
19 of each House, respectively, but applicable only with
20 respect to the procedure to be followed in that
21 House in the case of an enhanced premium tax cred-
22 it reform bill, and it supersedes other rules only to
23 the extent that it is inconsistent with such rules; and

24 (2) with full recognition of the constitutional
25 right of either House to change the rules (so far as

- 1 relating to the procedure of that House) at any time,
- 2 in the same manner, and to the same extent as in
- 3 the case of any other rule of that House.

