Jayapal	Morelle	Sewell
Jeffries	Morrison	Sherman
Johnson (GA)	Moskowitz	Simon
Johnson (TX)	Moulton	Smith (WA)
Kamlager-Dove	Mrvan	Sorensen
Kaptur	Mullin	Soto
Keating	Neal	Stansbury
Kelly (IL)	Neguse	Stanton
Kennedy (NY)	Norcross	Stevens
Khanna	Ocasio-Cortez	Strickland
Kiggans (VA)	Olszewski	Subramanyam
Krishnamoorthi	Omar	Suozzi
Landsman	Pallone	Sykes
Larsen (WA)	Panetta	Takano
Larson (CT)	Pappas	Thanedar
Latimer	Pelosi	Thompson (CA)
Lee (NV)	Perez	Thompson (MS)
Lee (PA)	Peters	Titus
Leger Fernandez	Pettersen	Tlaib
Levin	Pingree	Tokuda
Liccardo	Pocan	Tonko
Lieu	Pou	Torres (CA)
Lofgren	Pressley	Torres (NY)
Lynch	Quigley	Trahan
Magaziner	Ramirez	Tran
Mannion	Randall	Underwood
Matsui	Raskin	Vargas
McBride	Riley (NY)	Vasquez
McClain Delaney	Rivas	Veasey
McClellan	Ross	Velázquez
McCollum	Ruiz	Vindman
McDonald Rivet	Ryan	Walkinshaw
McGarvey	Salinas	Wasserman Schultz
McGovern	Sánchez	Waters
McIver	Scanlon	Watson Coleman
Meeks	Schakowsky	Whitesides
Menendez	Schneider	Williams (GA)
Meng	Scholten	Wilson (FL)
Mfume	Schrier	
Min	Scott (VA)	
Moore (WI)	Scott, David	

NOT VOTING—11

Courtney	LaLota	Nunn (IA)
Feenstra	McBath	Rogers (KY)
Garcia (TX)	Murphy	Swalwell
Hinson	Nadler	

□ 1106

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Ms. GARCIA of Texas. Mr. Speaker, due to illness, I was unable to vote today. Had I been able to vote, I would have voted NAY on Roll Call No. 343, Ordering the Previous Question on H. Res. 953; NO on Roll Call No. 344, H. Res. 953.

PERSONAL EXPLANATION

Mr. NADLER. Mr. Speaker, today, I missed votes due to a personal matter. Had I been present, I would have voted NAY on Roll Call No. 343 and NO on Roll Call No. 344.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Ferrari, one of its clerks, announced that the Senate has passed without amendment bills of the House of the following titles:

H.R. 131. An act to make certain modifications to the repayment for the Arkansas Valley Conduit in the State of Colorado.

H.R. 187. An act to provide for the standardization, consolidation, and publication of data relating to public outdoor recreational use of Federal waterway among Federal land and water management agencies, and for other purposes.

H.R. 410. An act to extend the Alaska Native Vietnam era veterans land allotment program, and for other purposes.

H.R. 1043. An act to direct the Secretary of the Interior to convey certain Federal land in Arizona to La Paz County, Arizona, and for other purposes.

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 355. An act to require the secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, to publish a final rule relating to nonclinical testing methods.

S. 594. An act to amend the Post-Katrina Management Reform Act of 2006 to repeal certain obsolete requirements, and for other purposes.

S. 612. An act to amend the Native American Tourism and Improving Visitor Experience Act to authorize grants to Indian tribes, tribal organizations, and Native Hawaiian organizations, and for other purposes.

S. 727. An act to correct the inequitable denial of enhanced retirement and annuity benefits to certain U.S. Customs and Border Protection Officers.

S. 856. An act to amend the Lobbying Disclosure Act of 1995 to clarify a provision relating to certain contents of registrations under that Act.

S. 861. An act to streamline the sharing of information among Federal disaster assistance agencies, to expedite the delivery of life-saving assistance to disaster survivors, to speed the recovery of communities from disasters, to protect the security and privacy of information provided by disaster survivors, and for other purposes.

S. 865. An act to amend the Lobbying Disclosure Act of 1995 to require certain disclosures by registrants regarding exemptions under the Foreign Agents Registration Act of 1938, as amended.

S. 1049. An act to direct the Office of Victims of Crime of the Department of Justice to continue implementing the anti-trafficking recommendations of the Government Accountability Office and to report to Congress regarding such implementation.

S. 3021. An act to amend title 18, United States Code, to enhance enforcement with respect to material depicting obscene child sexual abuse or constituting child pornography, and for other purposes.

S. 3490. An act to establish the Fort Ontario Holocaust Refugee Shelter National Historical Park, to designate the American's National Churchill Museum National Historic Landmark, and for other purposes.

The message also announced that pursuant to the provisions of Public Law 106–398, as amended by Public Law 108–7, the Chair, on behalf of the Democratic Leader, and in consultation with the Ranking Members of the Senate Committee on Armed Services and the Senate Committee on Finance, appoints the following individual to serve as a member of the United States-China Economic and Security Review Commission:

Michael Kuiken of the District of Columbia for a term beginning January 1, 2026 and expiring December 31, 2027.

ELECTING A MEMBER TO A CERTAIN STANDING COMMITTEE OF THE HOUSE OF REPRESENTATIVES

Mr. AGUILAR. Mr. Speaker, by direction of the Democratic Caucus, I offer a privileged resolution and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 954

Resolved, That the following named Member be, and is hereby, elected to the following standing committee of the House of Representatives:

COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY: Mr. Beyer.

Mr. AGUILAR (during the reading). Mr. Speaker, I ask unanimous consent that the resolution be considered as read.

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentleman from California?

There was no objection.

The resolution was agreed to.

A motion to reconsider was laid on the table.

□ 1110

LOWER HEALTH CARE PREMIUMS FOR ALL AMERICANS ACT

Mr. GUTHRIE. Mr. Speaker, pursuant to House Resolution 953, I call up the bill (H.R. 6703) to ensure access to affordable health insurance, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. GUEST). Pursuant to House Resolution 953, the bill is considered read.

The text of the bill is as follows:

H.R. 6703

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Lower Health Care Premiums for All Americans Act''.

TITLE I—IMPROVING HEALTH CARE OPTIONS FOR WORKERS

SEC. 101. ASSOCIATION HEALTH PLANS.

(a) TREATMENT OF GROUP OR ASSOCIATION OF EMPLOYERS.—Section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)) is amended by inserting after ''capacity'' the following: ''(including, for the purpose of establishing or maintaining a group health plan, a group or association of employers that satisfies the requirements of section 736(a))''.

(b) RULES APPLICABLE TO GROUP HEALTH PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181, et seq.) is amended by adding at the end the following:

''SEC. 736. RULES APPLICABLE TO GROUP HEALTH PLANS ESTABLISHED AND MAINTAINED BY A GROUP OR ASSOCIATION OF EMPLOYERS.

''(a) ASSOCIATION HEALTH PLANS.—A group or association of employers may maintain a group health plan, regardless of whether the employers composing such group or association are in the same industry, trade, or profession, if such group or association satisfies the following requirements:

''(1) GROUP OR ASSOCIATION REQUIREMENTS.—The group or association of employers—

''(A) shall—

''(i) have been formed and maintained in good faith for purposes other than providing health insurance coverage through a group health plan;

''(ii) establish a governing board or another indicator of formality as described in paragraph (2); and

''(iii) have existed for at least 2 years prior to offering a group health plan to the employees of such group or association; and

''(iv) make health insurance coverage under the group health plan offered by such group or association available—

''(I) to at least 51 employees; and

''(II) to all employees of the employer members, and any dependents of such employees;

''(B) may only provide health insurance coverage through the group health plan of the group or association—

''(i) to an employee of an employer member of the group or association or a dependent of such an employee; or

''(ii) as necessary to comply with part 6;

''(C) may include a health insurance issuer as an employer member, except that the group or association may not—

''(i) be a health insurance issuer; or

''(ii) be controlled or owned by a health insurance issuer (or a subsidiary or affiliate of a health insurance issuer).

''(D) may not condition the membership of an employer in the group or association on any health status-related factor (as described in section 702(a)(1)) relating to any employee or dependent of any employee of any employer member.

''(2) ORGANIZATIONAL REQUIREMENTS.—

''(A) GOVERNING BOARD OR FORMAL ORGANIZATION OF THE GROUP OR ASSOCIATION.—

''(i) IN GENERAL.—The group or association shall have—

''(I) a formal organizational structure with a governing board and by-laws; or

''(II) another structure or indicator of formality.

''(ii) REQUIREMENT.—Both structures described in subclauses (I) and (II) of clause (i) shall comply with the requirements described in subparagraph (B).

''(B) FORMAL ORGANIZATION STRUCTURE OF GROUP OR ASSOCIATION.—

''(i) IN GENERAL.—The functions and activities of the group or association shall be controlled by the employer members in substance and in fact.

''(ii) CONTROL.—The control described in clause (i) shall be satisfied so long as at least 75 percent of the positions on the board or other formal organizational structure are held by employer members.

''(iii) ELECTIONS.—Each position of the governing board or other formal organizational structure shall be subject to scheduled elections, as determined by the group or association, and each employer-member shall be able to cast only one vote in each such election.

''(C) GROUP HEALTH PLAN REQUIREMENTS.—

''(i) CONTROL.—The group health plan shall be controlled in substance and in fact by employer members participating in the group health plan.

''(ii) ELIGIBILITY VERIFICATION.—A plan fiduciary shall verify, on a regular basis and pursuant to reasonable monitoring procedures as established by the plan fiduciary, whether an individual is a self-employed individual if such individual (or a beneficiary thereof) participates in the group health plan on the basis that such individual is a self-employed individual.

''(iii) INELIGIBLE SELF-EMPLOYED INDIVIDUALS.—

''(I) IN GENERAL.—Subject to subclause (II) and except as required under part 6, in the case that the plan fiduciary determines that an individual who participates in the group health plan no longer meets the requirements under a self-employed individual during a plan year, the group health plan shall not make health insurance coverage available to such individual for any plan year following the plan year in which such determination was made.

''(II) REMEDIAL ACTION.—If, after the plan fiduciary determines that an individual described in clause (i) is not a self-employed individual, the individual furnishes to the plan fiduciary evidence proving that such individual is a self-employed individual, such individual shall be eligible to participate in the group health plan.

''(3) DISCRIMINATION AND PRE-EXISTING CONDITION PROTECTIONS.—A group health plan established and maintained by the group or association of employers under this section may not—

''(A) establish any rule for eligibility (including continued eligibility) of any individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual) to enroll for benefits under the terms of the plan that discriminates based on any health status-related factor that relates to such individual (consistent with the rules under section 702(a)(1));

''(B) require an individual (including an employee of an employer member or a self-employed individual, or a dependent of such employee or self-employed individual), as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor that relates to such individual (consistent with the rules under section 702(b)(1)); and

''(C) deny coverage under such plan on the basis of a pre-existing condition (consistent with the rules under section 2704 of the Public Health Service Act).

''(b) PREMIUM RATES FOR A GROUP OR ASSOCIATION OF EMPLOYERS.—

''(1) IN GENERAL.—A group health plan established and maintained by a group or association of employers that meets that requirements of this section may, to the extent not prohibited under State law—

''(A) establish base premium rates formed on an actuarially sound, modified community rating methodology that considers the pooling of all plan participant claims; and

''(B) utilize the specific risk profile of each employer member of such group or association to determine contribution rates for each such employer member's share of a premium by actuarially adjusting the established base premium rates.

''(2) ONLY SELF EMPLOYED INDIVIDUALS.—In the case that a group or association is composed only of self-employed individuals, the group health plan established by such group or association shall—

''(A) treat all such self-employed individuals as a single risk pool;

''(B) pool all plan participant claims; and

''(C) charge each plan participant the same premium rate.

''(c) TREATMENT OF SELF-EMPLOYED INDIVIDUALS.—For purposes of this section, an individual who is a self-employed individual shall be treated as—

''(1) an employer who may be a member of a group or association of employers;

''(2) an employee who may participate in a group health plan established and maintained by such group or association; and

''(3) a participant of the group health plan in which the individual participates, subject to the eligibility determination and monitoring requirements set forth in subsection (a)(2)(C)(i).

''(d) DETERMINATION OF EMPLOYER OR JOINT EMPLOYER STATUS.—The provision of health insurance coverage by a group or association of employers may not be construed as evidence for establishing an employer or joint employer relationship under any Federal or State law.

''(e) RULES OF CONSTRUCTION.—

''(1) NO EXEMPTION FROM PHSA.—Nothing in this section shall be construed to exempt a group health plan (as defined in section 733(a)(1)) offered through a group or association of employers from the requirements of this part or from the provisions of part A of title XXVII of the Public Health Service Act as incorporated by reference into this Act through section 715.

''(2) PRIOR OR FUTURE GUIDANCE.—Nothing in this section may be construed to limit or otherwise affect the ability of a group or association of employers from establishing a single plan multiple employer welfare arrangement as specified in any prior or future guidance issued by the Secretary of Labor that provides alternative pathways to qualifying as a group or association of employer for purposes of section 3(5).

''(f) DEFINITIONS.—In this section—

''(1) EMPLOYER MEMBER.—The term 'employer member' means—

''(A) an employer who is a member of such group or association of employers and employs at least 1 common law employee; or

''(B) a group made up solely of self-employed individuals, within which all of the self-employed individual members of such group or association are aggregated together as a single employer member group, provided that such group includes at least 20 self-employed individual members.

''(2) SELF-EMPLOYED INDIVIDUAL.—The term 'self-employed individual' means an individual who—

''(A) does not have any common law employees;

''(B) has a bona fide ownership right in a trade or business, regardless of whether such trade or business is incorporated or unincorporated;

''(C) earns a wage (as defined in section 3121(a) of the Internal Revenue Code of 1986) or self-employment income (as defined in section 1402(b) of such Code) from such trade or business; and

''(D) works at least 10 hours a week, or 40 hours per month, providing personal services to such trade or business.''.

(2) CLERICAL AMENDMENT.—The table of contents is amended by inserting after the item relating to section 734 the following:

''735. Standardized reporting format.

''736. Rules applicable to group health plans established and maintained by a group or association of employers.''.

SEC. 102. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following sentence: ''Such term shall not include a stop-loss policy obtained by a self-insured group health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop-loss policy obtained by such plan or sponsor.''.

(b) EFFECT ON OTHER LAWS.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) is amended by adding at the end the following:

''(10) The provisions of this title (including part 7 relating to group health plans) shall preempt State laws insofar as they may now or hereafter prevent an employee benefit plan that is a group health plan from insuring against the risk of excess or unexpected health plan claims losses.''.

SEC. 103. TREATMENT OF HEALTH REIMBURSEMENT ARRANGEMENTS INTEGRATED WITH INDIVIDUAL MARKET COVERAGE.

(a) IN GENERAL.—

(1) TREATMENT.—Section 9815(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''EXCEPTION.—Notwithstanding subsection (a)'' and inserting the following: ''EXCEPTIONS.—

''(1) SELF-INSURED GROUP HEALTH PLANS.—Notwithstanding subsection (a)'', and

(B) by adding at the end the following new paragraph:

''(2) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS.—

''(A) IN GENERAL.—For purposes of this subchapter, a custom health option and individual care expense arrangement shall be treated as meeting the requirements of section 9802 and sections 2705, 2711, 2713, and 2715 of title XXVII of the Public Health Service Act.

''(B) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS DEFINED.—For purposes of this section, the term 'custom health option and individual care expense arrangement' means a health reimbursement arrangement—

''(i) which is an employer-provided group health plan funded solely by employer contributions to provide payments or reimbursements for medical care subject to a maximum fixed dollar amount for a period,

''(ii) under which such payments or reimbursements may only be made for medical care provided during periods during which the individual is covered—

''(I) under individual health insurance coverage (other than coverage that consists solely of excepted benefits), or

''(II) under part A and B of title XVIII of the Social Security Act or part C of such title,

''(iii) which meets the nondiscrimination requirements of subparagraph (C),

''(iv) which meets the substantiation requirements of subparagraph (D), and

''(v) which meets the notice requirements of subparagraph (E).

''(C) NONDISCRIMINATION.—

''(i) IN GENERAL.—An arrangement meets the requirements of this subparagraph if an employer offering such arrangement to an employee within a specified class of employee—

''(I) offers such arrangement to all employees within such specified class on the same terms, and

''(II) does not offer any other group health plan (other than an account-based group health plan or a group health plan that consists solely of excepted benefits) to any employees within such specified class.

In the case of an employer who offers a group health plan provided through health insurance coverage in the small group market (that is subject to section 2701 of the Public Health Service Act) to all employees within such specified class, subclause (II) shall not apply to such group health plan.

''(ii) SPECIFIED CLASS OF EMPLOYEE.—For purposes of this subparagraph, any of the following may be designated as a specified class of employee:

''(I) Full-time employees.

''(II) Part-time employees.

''(III) Salaried employees.

''(IV) Non-salaried employees.

''(V) Employees whose primary site of employment is in the same rating area.

''(VI) Employees who are included in a unit of employees covered under a collective bargaining agreement to which the employer is subject (determined under rules similar to the rules of section 105(h)).

''(VII) Employees who have not met a group health plan, or health insurance issuer offering group health insurance coverage, waiting period requirement that satisfies section 2708 of the Public Health Service Act.

''(VIII) Seasonal employees.

''(IX) Employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

''(X) Under such rules as the Secretary may prescribe, employees who are hired for temporary placement with an unrelated person that is not the common law employer.

''(XI) Such other classes of employees as the Secretary may designate.

An employer may designate (in such manner as is prescribed by the Secretary) two or more of the classes described in the preceding subclauses as the specified class of employees to which the arrangement is offered for purposes of applying this subparagraph.

''(iii) SPECIAL RULE FOR NEW HIRES.—An employer may designate prospectively so much of a specified class of employees as are hired after a date set by the employer. Such subclass of employees shall be treated as the specified class for purposes of applying clause (i).

''(iv) RULES FOR DETERMINING TYPE OF EMPLOYEE.—For purposes for clause (ii), any determination of full-time, part-time, or seasonal employment status shall be made under rules similar to the rules of section 105(h) or 4980H, whichever the employer elects for the plan year. Such election shall apply with respect to all employees of the employer for the plan year.

''(v) PERMITTED VARIATION.—For purposes of clause (i)(I), an arrangement shall not fail to be treated as provided on the same terms within a specified class merely because the maximum dollar amount of payments and reimbursements which may be made under the terms of the arrangement for the year with respect to each employee within such class—

''(I) increases as additional dependents of the employee are covered under the arrangement, and

''(II) increases with respect to a participant as the age of the participant increases, but not in excess of an amount equal to 300 percent of the lowest maximum dollar amount with respect to such a participant determined without regard to age.

''(D) SUBSTANTIATION REQUIREMENTS.—An arrangement meets the requirements of this subparagraph if the arrangement has reasonable procedures to substantiate—

''(i) that the participant and any dependents are, or will be, enrolled in coverage described in subparagraph (B)(ii) as of the beginning of the plan year of the arrangement (or as of the beginning of coverage under the arrangement in the case of an employee who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under subparagraph (E) (determined without regard to clause (iii) thereof), and

''(ii) any requests made for payment or reimbursement of medical care under the arrangement and that the participant and any dependents remain so enrolled.

''(E) NOTICE.—

''(i) IN GENERAL.—Except as provided in clause (iii), an arrangement meets the requirements of this subparagraph if, under the arrangement, each employee eligible to participate is, not later than 60 days before the beginning of the plan year, given written notice of the employee's rights and obligations under the arrangement which—

''(I) is sufficiently accurate and comprehensive to apprise the employee of such rights and obligations, and

''(II) is written in a manner calculated to be understood by the average employee eligible to participate.

''(ii) NOTICE REQUIREMENTS.—Such notice shall include such information as the Secretary may by regulation prescribe.

''(iii) NOTICE DEADLINE FOR CERTAIN EMPLOYEES.—In the case of an employee—

''(I) who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under clause (i) (determined without regard to this clause), or

''(II) whose employer is first established fewer than 120 days before the beginning of the first plan year of the arrangement,

the requirements of this subparagraph shall be treated as met if the notice required under clause (i) is provided not later than the date the arrangement may take effect with respect to such employee.''.

(2) TREATMENT OF CURRENT RULES RELATING TO CERTAIN ARRANGEMENTS.—

(A) NO INFERENCE.—To the extent not inconsistent with the amendments made by this subsection—

(i) no inference shall be made from such amendments with respect to the rules prescribed in the Federal Register on June 20, 2019, (84 Fed. Reg. 28888) relating to health reimbursement arrangements and other account-based group health plans, and

(ii) any reference to custom health option and individual care expense arrangements shall for purposes of such rules be treated as including a reference to individual coverage health reimbursement arrangements.

(B) OTHER CONFORMING OF RULES.—The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall modify such rules as may be necessary to conform to the amendments made by this subsection.

(3) PARTICIPANTS IN CHOICE ARRANGEMENT ELIGIBLE FOR PURCHASE OF EXCHANGE INSURANCE UNDER CAFETERIA PLAN.—Section 125(f)(3) of such Code is amended by adding at the end the following new subparagraph:

''(C) EXCEPTION FOR PARTICIPANTS IN CHOICE ARRANGEMENT.—Subparagraph (A) shall not apply in the case of an employee participating in a custom health option and individual care expense arrangement (within the meaning of section 9815(b)(2)) offered by the employee's employer.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after December 31, 2025.

(b) INCLUSION OF CHOICE ARRANGEMENT PERMITTED BENEFITS ON W–2.—

(1) IN GENERAL.—Section 6051(a) of such Code is amended by striking ''and'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting '', and'', and by inserting after paragraph (19) the following new paragraph:

''(20) the total amount of permitted benefits for enrolled individuals under a custom health option and individual care expense arrangement (as defined in section 9815(b)(2)) with respect to such employee.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2025.

TITLE II—LOWERING HEALTH CARE PREMIUMS FOR EVERYONE

SEC. 201. OVERSIGHT OF PHARMACY BENEFIT MANAGEMENT SERVICES.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in part D (42 U.S.C. 300gg–111 et seq.), by adding at the end the following new section:

''SEC. 2799A–11. OVERSIGHT OF ENTITIES THAT PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 30 months

after the date of enactment of this section (referred to in this subsection and subsection (b) as the 'effective date'), a group health plan or a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefit management services on behalf of such a plan or issuer, shall not enter into a contract, including an extension or renewal of a contract, entered into on or after the effective date, with an applicable entity unless such applicable entity agrees to—

''(1) not limit or delay the disclosure of information to the group health plan (including such a plan offered through a health insurance issuer) in such a manner that prevents an entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage from making the reports described in subsection (b); and

''(2) provide the entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer relevant information necessary to make the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after the effective date, in the case of any contract between a group health plan or a health insurance issuer offering group health insurance coverage offered in connection with such a plan and an entity providing pharmacy benefit management services on behalf of such plan or issuer, including an extension or renewal of such a contract, entered into on or after the effective date, the entity providing pharmacy benefit management services on behalf of such a group health plan or health insurance issuer, not less frequently than every 6 months (or, at the request of a group health plan, not less frequently than quarterly, and under the same conditions, terms, and cost of the semiannual report under this subsection), shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in plain language, in a machine-readable format, and as the Secretary may determine, other formats. Each such report shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan or group health insurance coverage offered by a health insurance issuer in connection with a group health plan during each reporting period—

''(A) in the case of a group health plan that is offered by a specified large employer or that is a specified large plan, and is not offered as health insurance coverage, or in the case of health insurance coverage for which the election under paragraph (3) is made for the applicable reporting period—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

''(I) the contracted compensation paid by the group health plan or health insurance issuer for each covered drug (identified by the National Drug Code) to the entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer;

''(II) the contracted compensation paid to the pharmacy, by any entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer, for each covered drug (identified by the National Drug Code);

''(III) for each such claim, the difference between the amount paid under subclause (I) and the amount paid under subclause (II);

''(IV) the proprietary name, established name or proper name, and National Drug Code;

''(V) for each claim for the drug (including original prescriptions and refills) and for each dosage unit of the drug for which a claim was filed, the type of dispensing channel used to furnish the drug, including retail, mail order, or specialty pharmacy;

''(VI) with respect to each drug dispensed, for each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants and beneficiaries for whom a claim for such drug was filed through the applicable dispensing channel;

''(CC) dosage units and dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(VII) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan or coverage after rebates, fees, alternative discounts, or other remuneration received from applicable entities;

''(VIII) the total amount of out-of-pocket spending by participants and beneficiaries on such drug, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or coverage, or for which no claim is submitted under the plan or coverage;

''(IX) the total net spending on the drug;

''(X) the total amount received, or expected to be received, by the plan or issuer from any applicable entity in rebates, fees, alternative discounts, or other remuneration;

''(XI) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of such drug or spending on such drug; and

''(XII) to the extent feasible, information on the total amount of remuneration for such drug, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment assistance on behalf of such drug manufacturer), to the participants and beneficiaries enrolled in such plan or coverage;

''(ii) a list of each therapeutic class (as defined by the Secretary) for which a claim was filed under the group health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic class—

''(I) the total gross spending on drugs in such class before rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(II) the net spending in such class after such rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(III) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of drugs or drug spending;

''(IV) the average net spending per 30-day supply and per 90-day supply by the plan or by the issuer with respect to such coverage and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period;

''(V) the number of participants and beneficiaries who filled a prescription for a drug in such class, including the National Drug Code for each such drug;

''(VI) if applicable, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that class; and

''(VII) the total out-of-pocket spending under the plan or coverage by participants and beneficiaries, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or coverage or for which no claim is submitted under the plan or coverage;

''(iii) with respect to any drug for which gross spending under the group health plan or health insurance coverage exceeded $10,000 during the reporting period or, in the case that gross spending under the group health plan or coverage exceeded $10,000 during the reporting period with respect to fewer than 50 drugs, with respect to the 50 prescription drugs with the highest spending during the reporting period—

''(I) a list of all other drugs in the same therapeutic class as such drug;

''(II) if applicable, the rationale for the formulary placement of such drug in that therapeutic category or class, selected from a list of standard rationales established by the Secretary, in consultation with stakeholders; and

''(III) any change in formulary placement compared to the prior plan year; and

''(iv) in the case that such plan or issuer (or an entity providing pharmacy benefit management services on behalf of such plan or issuer) has an affiliated pharmacy or pharmacy under common ownership, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives funded by an entity providing pharmacy benefit services—

''(I) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies;

''(II) the percentage of total prescriptions dispensed by such pharmacies to participants or beneficiaries in such plan or coverage; and

''(III) a list of all drugs dispensed by such pharmacies to participants or beneficiaries enrolled in such plan or coverage, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan or issuer, and to participants and beneficiaries;

''(bb) the median amount charged to such plan or issuer, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other

pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan or coverage and to participants and beneficiaries, that is available from any pharmacy included in the network of such plan or coverage; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount; and

''(B) with respect to any group health plan, including group health insurance coverage offered in connection with such a plan, regardless of whether the plan or coverage is offered by a specified large employer or whether it is a specified large plan—

''(i) a summary document for the group health plan that includes such information described in clauses (i) through (iv) of subparagraph (A), as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking), that the Secretary determines useful to group health plans for purposes of selecting pharmacy benefit management services, such as an estimated net price to group health plan and participant or beneficiary, a cost per claim, the fee structure or reimbursement model, and estimated cost per participant or beneficiary;

''(ii) a summary document for plans and issuers to provide to participants and beneficiaries, which shall be made available to participants or beneficiaries upon request to their group health plan (including in the case of group health insurance coverage offered in connection with such a plan), that—

''(I) contains such information described in clauses (iii), (iv), (v), and (vi), as applicable, as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking) that the Secretary determines useful to participants or beneficiaries in better understanding the plan or coverage or benefits under such plan or coverage;

''(II) contains only aggregate information; and

''(III) states that participants and beneficiaries may request specific, claims-level information required to be furnished under subsection (c) from the group health plan or health insurance issuer;

''(iii) with respect to drugs covered by such plan or coverage during such reporting period—

''(I) the total net spending by the plan or coverage for all such drugs;

''(II) the total amount received, or expected to be received, by the plan or issuer from any applicable entity in rebates, fees, alternative discounts, or other remuneration; and

''(III) to the extent feasible, information on the total amount of remuneration for such drugs, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment assistance on behalf of such drug manufacturer) to participants and beneficiaries;

''(iv) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act) to brokerage firms, brokers, consultants, advisors, or any other individual or firm, for—

''(I) the referral of the group health plan's or health insurance issuer's business to an entity providing pharmacy benefit management services, including the identity of the recipient of such amounts;

''(II) consideration of the entity providing pharmacy benefit management services by the group health plan or health insurance issuer; or

''(III) the retention of the entity by the group health plan or health insurance issuer;

''(v) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in such plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(vi) total gross spending on all drugs under the plan or coverage during the reporting period.

''(3) OPT-IN FOR GROUP HEALTH INSURANCE COVERAGE OFFERED BY A SPECIFIED LARGE EMPLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In the case of group health insurance coverage offered in connection with a group health plan that is offered by a specified large employer or is a specified large plan, such group health plan may, on an annual basis, for plan years beginning on or after the date that is 30 months after the date of enactment of this section, elect to require an entity providing pharmacy benefit management services on behalf of the health insurance issuer to submit to such group health plan a report that includes all of the information described in paragraph (2)(A), in addition to the information described in paragraph (2)(B).

''(4) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan or a health insurance issuer offering group health insurance coverage shall report information under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a group health plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—

''(i) Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) Nothing in this section shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, group health plans, including with respect to group health insurance coverage offered in connection with a group health plan, shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for entities providing pharmacy benefit management services on behalf of the group health plan or health insurance issuer offering group health insurance coverage to submit reports to group health plans under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent an entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, issuer, or entity may not—

''(i) restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury; or

''(ii) prevent disclosure for the purposes of subsection (c), or any other public disclosure requirement under this section.

''(G) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required with respect to any group health plan established by a plan sponsor that is, or is affiliated with, a drug manufacturer, drug wholesaler, or other direct participant in the drug supply chain, in order to prevent anticompetitive behavior.

''(5) STANDARD FORMAT AND REGULATIONS.—

''(A) IN GENERAL.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking a standard format for entities providing pharmacy benefit management services on behalf of group health plans and health insurance issuers offering group health insurance coverage, to submit reports required under paragraph (1).

''(B) ADDITIONAL REGULATIONS.—Not later than 18 months after the date of enactment of this section, the Secretary shall, through rulemaking, promulgate any other final regulations necessary to implement the requirements of this section. In promulgating such regulations, the Secretary shall, to the extent practicable, align the reporting requirements under this section with the reporting requirements under section 2799A–10.

''(c) REQUIREMENT TO PROVIDE INFORMATION TO PARTICIPANTS OR BENEFICIARIES.—A group health plan, including with respect to group health insurance coverage offered in

connection with a group health plan, upon request of a participant or beneficiary, shall provide to such participant or beneficiary—

''(1) the summary document described in subsection (b)(2)(B)(ii); and

''(2) the information described in subsection (b)(2)(A)(i)(III) with respect to a claim made by or on behalf of such participant or beneficiary.

''(d) ENFORCEMENT.—

''(1) IN GENERAL.—The Secretary shall enforce this section. The enforcement authority under this subsection shall apply only with respect to group health plans (including group health insurance coverage offered in connection with such a plan) to which the requirements of subparts I and II of part A and part D apply in accordance with section 2722, and with respect to entities providing pharmacy benefit management services on behalf of such plans and applicable entities providing services on behalf of such plans.

''(2) FAILURE TO PROVIDE INFORMATION.—A group health plan, a health insurance issuer offering group health insurance coverage, an entity providing pharmacy benefit management services on behalf of such a plan or issuer, or an applicable entity providing services on behalf of such a plan or issuer that violates subsection (a); an entity providing pharmacy benefit management services on behalf of such a plan or issuer that fails to provide the information required under subsection (b); or a group health plan that fails to provide the information required under subsection (c), shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—A health insurance issuer, an entity providing pharmacy benefit management services, or a third party administrator providing services on behalf of such issuer offered by a health insurance issuer that knowingly provides false information under this section shall be subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information. Such civil monetary penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under such section.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with the requirements in this section.

''(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer, or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary to a report described in subsection (b)(1) or information related to compliance with subsections (a), (b), (c), or (d) by such issuer, plan, or entity.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE ENTITY.—The term 'applicable entity' means—

''(A) an applicable group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator (or other purchasing entity designed to aggregate rebates), or associated third party;

''(B) any subsidiary, parent, affiliate, or subcontractor of a group health plan, health insurance issuer, entity that provides pharmacy benefit management services on behalf of such a plan or issuer, or any entity described in subparagraph (A); or

''(C) such other entity as the Secretary may specify through rulemaking.

''(2) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization that is affiliated with or under common ownership with an entity providing pharmacy benefit management services.

''(3) CONTRACTED COMPENSATION.—The term 'contracted compensation' means the sum of any ingredient cost and dispensing fee for a drug (inclusive of the out-of-pocket costs to the participant or beneficiary), or another analogous compensation structure that the Secretary may specify through regulations.

''(4) GROSS SPENDING.—The term 'gross spending', with respect to prescription drug benefits under a group health plan or health insurance coverage, means the amount spent by a group health plan or health insurance issuer on prescription drug benefits, calculated before the application of rebates, fees, alternative discounts, or other remuneration.

''(5) NET SPENDING.—The term 'net spending', with respect to prescription drug benefits under a group health plan or health insurance coverage, means the amount spent by a group health plan or health insurance issuer on prescription drug benefits, calculated after the application of rebates, fees, alternative discounts, or other remuneration.

''(6) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(7) REMUNERATION.—The term 'remuneration' has the meaning given such term by the Secretary through rulemaking, which shall be reevaluated by the Secretary every 5 years.

''(8) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a single employer, with respect to a calendar year or a plan year, as applicable, an employer who employed an average of at least 100 employees on business days during the preceding calendar year or plan year and who employs at least 1 employee on the first day of the calendar year or plan year.

''(9) SPECIFIED LARGE PLAN.—The term 'specified large plan' means a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a plan sponsor described in clause (ii) or (iii) of section 3(16)(B) of the Employee Retirement Income Security Act of 1974 that had an average of at least 100 participants on business days during the preceding calendar year or plan year, as applicable.

''(10) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''; and

(2) in section 2723 (42 U.S.C. 300gg–22)—

(A) in subsection (a)—

(i) in paragraph (1), by inserting ''(other than section 2799A–11)'' after ''part D''; and

(ii) in paragraph (2), by inserting ''(other than section 2799A–11)'' after ''part D''; and

(B) in subsection (b)—

(i) in paragraph (1), by inserting ''(other than section 2799A–11)'' after ''part D'';

(ii) in paragraph (2)(A), by inserting ''(other than section 2799A–11)'' after ''part D''; and

(iii) in paragraph (2)(C)(ii), by inserting ''(other than section 2799A–11)'' after ''part D''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended—

(A) in subpart B of part 7 (29 U.S.C. 1185 et seq.), by adding at the end the following:

''SEC. 726. OVERSIGHT OF ENTITIES THAT PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 30 months after the date of enactment of this section (referred to in this subsection and subsection (b) as the 'effective date'), a group health plan or a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefit management services on behalf of such a plan or issuer, shall not enter into a contract, including an extension or renewal of a contract, entered into on or after the effective date, with an applicable entity unless such applicable entity agrees to—

''(1) not limit or delay the disclosure of information to the group health plan (including such a plan offered through a health insurance issuer) in such a manner that prevents an entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage from making the reports described in subsection (b); and

''(2) provide the entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer relevant information necessary to make the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after the effective date, in the case of any contract between a group health plan or a health insurance issuer offering group health insurance coverage offered in connection with such a plan and an entity providing pharmacy benefit management services on behalf of such plan or issuer, including an extension or renewal of such a contract, entered into on or after the effective date, the entity providing pharmacy benefit management services on behalf of such a group health plan or health insurance issuer, not less frequently than every 6 months (or, at the request of a group health plan, not less frequently than quarterly, and under the same conditions, terms, and cost of the semi-annual report under this subsection), shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in plain language, in a machine-readable format, and as the Secretary may determine, other formats. Each such report shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan or group health insurance coverage offered by a health insurance issuer in connection with a group health plan during each reporting period—

''(A) in the case of a group health plan that is offered by a specified large employer or that is a specified large plan, and is not offered as health insurance coverage, or in the case of health insurance coverage for which the election under paragraph (3) is made for the applicable reporting period—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

''(I) the contracted compensation paid by the group health plan or health insurance issuer for each covered drug (identified by the National Drug Code) to the entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer;

''(II) the contracted compensation paid to the pharmacy, by any entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan or health insurance issuer, for each covered drug (identified by the National Drug Code);

''(III) for each such claim, the difference between the amount paid under subclause (I) and the amount paid under subclause (II);

''(IV) the proprietary name, established name or proper name, and National Drug Code;

''(V) for each claim for the drug (including original prescriptions and refills) and for each dosage unit of the drug for which a claim was filed, the type of dispensing channel used to furnish the drug, including retail, mail order, or specialty pharmacy;

''(VI) with respect to each drug dispensed, for each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants and beneficiaries for whom a claim for such drug was filed through the applicable dispensing channel;

''(CC) dosage units and dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(VII) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan or coverage after rebates, fees, alternative discounts, or other remuneration received from applicable entities;

''(VIII) the total amount of out-of-pocket spending by participants and beneficiaries on such drug, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or coverage, or for which no claim is submitted under the plan or coverage;

''(IX) the total net spending on the drug;

''(X) the total amount received, or expected to be received, by the plan or issuer from any applicable entity in rebates, fees, alternative discounts, or other remuneration;

''(XI) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of such drug or spending on such drug; and

''(XII) to the extent feasible, information on the total amount of remuneration for such drug, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment assistance on behalf of such drug manufacturer), to the participants and beneficiaries enrolled in such plan or coverage;

''(ii) a list of each therapeutic class (as defined by the Secretary) for which a claim was filed under the group health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic class—

''(I) the total gross spending on drugs in such class before rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(II) the net spending in such class after such rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(III) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of drugs or drug spending;

''(IV) the average net spending per 30-day supply and per 90-day supply by the plan or by the issuer with respect to such coverage and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period;

''(V) the number of participants and beneficiaries who filled a prescription for a drug in such class, including the National Drug Code for each such drug;

''(VI) if applicable, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that class; and

''(VII) the total out-of-pocket spending under the plan or coverage by participants and beneficiaries, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or coverage or for which no claim is submitted under the plan or coverage;

''(iii) with respect to any drug for which gross spending under the group health plan or health insurance coverage exceeded $10,000 during the reporting period or, in the case that gross spending under the group health plan or coverage exceeded $10,000 during the reporting period with respect to fewer than 50 drugs, with respect to the 50 prescription drugs with the highest spending during the reporting period—

''(I) a list of all other drugs in the same therapeutic class as such drug;

''(II) if applicable, the rationale for the formulary placement of such drug in that therapeutic category or class, selected from a list of standard rationales established by the Secretary, in consultation with stakeholders; and

''(III) any change in formulary placement compared to the prior plan year; and

''(iv) in the case that such plan or issuer (or an entity providing pharmacy benefit management services on behalf of such plan or issuer) has an affiliated pharmacy or pharmacy under common ownership, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost sharing assistance incentives funded by an entity providing pharmacy benefit services—

''(I) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies;

''(II) the percentage of total prescriptions dispensed by such pharmacies to participants or beneficiaries in such plan or coverage; and

''(III) a list of all drugs dispensed by such pharmacies to participants or beneficiaries enrolled in such plan or coverage, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan or issuer, and to participants and beneficiaries;

''(bb) the median amount charged to such plan or issuer, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan or coverage and to participants and beneficiaries, that is available from any pharmacy included in the network of such plan or coverage; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount; and

''(B) with respect to any group health plan, including group health insurance coverage offered in connection with such a plan, regardless of whether the plan or coverage is offered by a specified large employer or whether it is a specified large plan—

''(i) a summary document for the group health plan that includes such information described in clauses (i) through (iv) of subparagraph (A), as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking), that the Secretary determines useful to group health plans for purposes of selecting pharmacy benefit management services, such as an estimated net price to group health plan and participant or beneficiary, a cost per claim, the fee structure or reimbursement model, and estimated cost per participant or beneficiary;

''(ii) a summary document for plans and issuers to provide to participants and beneficiaries, which shall be made available to participants or beneficiaries upon request to their group health plan (including in the case of group health insurance coverage offered in connection with such a plan), that—

''(I) contains such information described in clauses (iii), (iv), (v), and (vi), as applicable, as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking) that the Secretary determines useful to participants or beneficiaries in better understanding the plan or coverage or benefits under such plan or coverage;

''(II) contains only aggregate information; and

''(III) states that participants and beneficiaries may request specific, claims-level information required to be furnished under subsection (c) from the group health plan or health insurance issuer;

''(iii) with respect to drugs covered by such plan or coverage during such reporting period—

''(I) the total net spending by the plan or coverage for all such drugs;

''(II) the total amount received, or expected to be received, by the plan or issuer from any applicable entity in rebates, fees, alternative discounts, or other remuneration; and

''(III) to the extent feasible, information on the total amount of remuneration for such drugs, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment

assistance on behalf of such drug manufacturer) to participants and beneficiaries;

''(iv) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA)) to brokerage firms, brokers, consultants, advisors, or any other individual or firm, for—

''(I) the referral of the group health plan's or health insurance issuer's business to an entity providing pharmacy benefit management services, including the identity of the recipient of such amounts;

''(II) consideration of the entity providing pharmacy benefit management services by the group health plan or health insurance issuer; or

''(III) the retention of the entity by the group health plan or health insurance issuer;

''(v) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in such plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(vi) total gross spending on all drugs under the plan or coverage during the reporting period.

''(3) OPT-IN FOR GROUP HEALTH INSURANCE COVERAGE OFFERED BY A SPECIFIED LARGE EMPLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In the case of group health insurance coverage offered in connection with a group health plan that is offered by a specified large employer or is a specified large plan, such group health plan may, on an annual basis, for plan years beginning on or after the date that is 30 months after the date of enactment of this section, elect to require an entity providing pharmacy benefit management services on behalf of the health insurance issuer to submit to such group health plan a report that includes all of the information described in paragraph (2)(A), in addition to the information described in paragraph (2)(B).

''(4) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan or a health insurance issuer offering group health insurance coverage shall report information under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a group health plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—

''(i) Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) Nothing in this section shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, group health plans, including with respect to group health insurance coverage offered in connection with a group health plan, shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for entities providing pharmacy benefit management services on behalf of the group health plan or health insurance issuer offering group health insurance coverage to submit reports to group health plans under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent an entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, issuer, or entity may not—

''(i) restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury; or

''(ii) prevent disclosure for the purposes of subsection (c), or any other public disclosure requirement under this section.

''(G) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required with respect to any group health plan established by a plan sponsor that is, or is affiliated with, a drug manufacturer, drug wholesaler, or other direct participant in the drug supply chain, in order to prevent anticompetitive behavior.

''(5) STANDARD FORMAT AND REGULATIONS.—

''(A) IN GENERAL.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking a standard format for entities providing pharmacy benefit management services on behalf of group health plans and health insurance issuers offering group health insurance coverage, to submit reports required under paragraph (1).

''(B) ADDITIONAL REGULATIONS.—Not later than 18 months after the date of enactment of this section, the Secretary shall, through rulemaking, promulgate any other final regulations necessary to implement the requirements of this section. In promulgating such regulations, the Secretary shall, to the extent practicable, align the reporting requirements under this section with the reporting requirements under section 725.

''(c) REQUIREMENT TO PROVIDE INFORMATION TO PARTICIPANTS OR BENEFICIARIES.—A group health plan, including with respect to group health insurance coverage offered in connection with a group health plan, upon request of a participant or beneficiary, shall provide to such participant or beneficiary—

''(1) the summary document described in subsection (b)(2)(B)(ii); and

''(2) the information described in subsection (b)(2)(A)(i)(III) with respect to a claim made by or on behalf of such participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer, or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary to a report described in subsection (b)(1) or information related to compliance with subsections (a), (b), or (c) of this section or section 502(c)(13) by such issuer, plan, or entity.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE ENTITY.—The term 'applicable entity' means—

''(A) an applicable group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator (or other purchasing entity designed to aggregate rebates), or associated third party;

''(B) any subsidiary, parent, affiliate, or subcontractor of a group health plan, health insurance issuer, entity that provides pharmacy benefit management services on behalf of such a plan or issuer, or any entity described in subparagraph (A); or

''(C) such other entity as the Secretary may specify through rulemaking.

''(2) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization that is affiliated with or under common ownership with an entity providing pharmacy benefit management services.

''(3) CONTRACTED COMPENSATION.—The term 'contracted compensation' means the sum of any ingredient cost and dispensing fee for a drug (inclusive of the out-of-pocket costs to the participant or beneficiary), or another analogous compensation structure that the Secretary may specify through regulations.

''(4) GROSS SPENDING.—The term 'gross spending', with respect to prescription drug benefits under a group health plan or health insurance coverage, means the amount spent by a group health plan or health insurance issuer on prescription drug benefits, calculated before the application of rebates, fees, alternative discounts, or other remuneration.

''(5) NET SPENDING.—The term 'net spending', with respect to prescription drug benefits under a group health plan or health insurance coverage, means the amount spent by a group health plan or health insurance issuer on prescription drug benefits, calculated after the application of rebates, fees, alternative discounts, or other remuneration.

''(6) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B).

''(7) REMUNERATION.—The term 'remuneration' has the meaning given such term by

the Secretary through rulemaking, which shall be reevaluated by the Secretary every 5 years.

''(8) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a single employer, with respect to a calendar year or a plan year, as applicable, an employer who employed an average of at least 100 employees on business days during the preceding calendar year or plan year and who employs at least 1 employee on the first day of the calendar year or plan year.

''(9) SPECIFIED LARGE PLAN.—The term 'specified large plan' means a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a plan sponsor described in clause (ii) or (iii) of section 3(16)(B) that had an average of at least 100 participants on business days during the preceding calendar year or plan year, as applicable.

''(10) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).'';

(B) in section 502 (29 U.S.C. 1132)—

(i) in subsection (a)(6), by striking ''or (9)'' and inserting ''(9), or (13)'';

(ii) in subsection (b)(3), by striking ''under subsection (c)(9)'' and inserting ''under paragraphs (9) and (13) of subsection (c)''; and

(iii) in subsection (c), by adding at the end the following:

''(13) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO OVERSIGHT OF PHARMACY BENEFIT MANAGEMENT SERVICES.—

''(A) FAILURE TO PROVIDE INFORMATION.—The Secretary may impose a penalty against a plan administrator of a group health plan, a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefit management services on behalf of such a plan or issuer, or an applicable entity (as defined in section 726(f)) that violates section 726(a); an entity providing pharmacy benefit management services on behalf of such a plan or issuer that fails to provide the information required under section 726(b); or any person who causes a group health plan to fail to provide the information required under section 726(c), in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(B) FALSE INFORMATION.—The Secretary may impose a penalty against a plan administrator of a group health plan, a health insurance issuer offering group health insurance coverage, an entity providing pharmacy benefit management services, or an applicable entity (as defined in section 726(f)) that knowingly provides false information under section 726, in an amount not to exceed $100,000 for each item of false information. Such penalty shall be in addition to other penalties as may be prescribed by law.

''(C) WAIVERS.—The Secretary may waive penalties under subparagraph (A), or extend the period of time for compliance with a requirement of this section, for an entity in violation of section 726 that has made a good-faith effort to comply with the requirements of section 726.''; and

(C) in section 732(a) (29 U.S.C. 1191a(a)), by striking ''section 711'' and inserting ''sections 711 and 726''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 725 the following new item:

''Sec. 726. Oversight of entities that provide pharmacy benefit management services.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end of subchapter B the following:

''SEC. 9826. OVERSIGHT OF ENTITIES THAT PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 30 months after the date of enactment of this section (referred to in this subsection and subsection (b) as the 'effective date'), a group health plan, or an entity providing pharmacy benefit management services on behalf of such a plan, shall not enter into a contract, including an extension or renewal of a contract, entered into on or after the effective date, with an applicable entity unless such applicable entity agrees to—

''(1) not limit or delay the disclosure of information to the group health plan in such a manner that prevents an entity providing pharmacy benefit management services on behalf of a group health plan from making the reports described in subsection (b); and

''(2) provide the entity providing pharmacy benefit management services on behalf of a group health plan relevant information necessary to make the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after the effective date, in the case of any contract between a group health plan and an entity providing pharmacy benefit management services on behalf of such plan, including an extension or renewal of such a contract, entered into on or after the effective date, the entity providing pharmacy benefit management services on behalf of such a group health plan, not less frequently than every 6 months (or, at the request of a group health plan, not less frequently than quarterly, and under the same conditions, terms, and cost of the semiannual report under this subsection), shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in plain language, in a machine-readable format, and as the Secretary may determine, other formats. Each such report shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan during each reporting period—

''(A) in the case of a group health plan that is offered by a specified large employer or that is a specified large plan, and is not offered as health insurance coverage, or in the case of health insurance coverage for which the election under paragraph (3) is made for the applicable reporting period—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

''(I) the contracted compensation paid by the group health plan for each covered drug (identified by the National Drug Code) to the entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan;

''(II) the contracted compensation paid to the pharmacy, by any entity providing pharmacy benefit management services or other applicable entity on behalf of the group health plan, for each covered drug (identified by the National Drug Code);

''(III) for each such claim, the difference between the amount paid under subclause (I) and the amount paid under subclause (II);

''(IV) the proprietary name, established name or proper name, and National Drug Code;

''(V) for each claim for the drug (including original prescriptions and refills) and for each dosage unit of the drug for which a claim was filed, the type of dispensing channel used to furnish the drug, including retail, mail order, or specialty pharmacy;

''(VI) with respect to each drug dispensed, for each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants and beneficiaries for whom a claim for such drug was filed through the applicable dispensing channel;

''(CC) dosage units and dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(VII) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan after rebates, fees, alternative discounts, or other remuneration received from applicable entities;

''(VIII) the total amount of out-of-pocket spending by participants and beneficiaries on such drug, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan, or for which no claim is submitted under the plan;

''(IX) the total net spending on the drug;

''(X) the total amount received, or expected to be received, by the plan from any applicable entity in rebates, fees, alternative discounts, or other remuneration;

''(XI) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of such drug or spending on such drug; and

''(XII) to the extent feasible, information on the total amount of remuneration for such drug, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment assistance on behalf of such drug manufacturer), to the participants and beneficiaries enrolled in such plan;

''(ii) a list of each therapeutic class (as defined by the Secretary) for which a claim was filed under the group health plan during the reporting period, and, with respect to each such therapeutic class—

''(I) the total gross spending on drugs in such class before rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(II) the net spending in such class after such rebates, price concessions, alternative discounts, or other remuneration from applicable entities;

''(III) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts, or other remuneration from such entities—

''(aa) for claims incurred during the reporting period; and

''(bb) that is related to utilization of drugs or drug spending;

''(IV) the average net spending per 30-day supply and per 90-day supply by the plan and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period;

''(V) the number of participants and beneficiaries who filled a prescription for a drug in such class, including the National Drug Code for each such drug;

''(VI) if applicable, a description of the formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that class; and

''(VII) the total out-of-pocket spending under the plan by participants and beneficiaries, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or for which no claim is submitted under the plan;

''(iii) with respect to any drug for which gross spending under the group health plan exceeded $10,000 during the reporting period or, in the case that gross spending under the group health plan exceeded $10,000 during the reporting period with respect to fewer than 50 drugs, with respect to the 50 prescription drugs with the highest spending during the reporting period—

''(I) a list of all other drugs in the same therapeutic class as such drug;

''(II) if applicable, the rationale for the formulary placement of such drug in that therapeutic category or class, selected from a list of standard rationales established by the Secretary, in consultation with stakeholders; and

''(III) any change in formulary placement compared to the prior plan year; and

''(iv) in the case that such plan (or an entity providing pharmacy benefit management services on behalf of such plan) has an affiliated pharmacy or pharmacy under common ownership, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost sharing assistance incentives funded by an entity providing pharmacy benefit services—

''(I) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in the plan to fill prescriptions at mail order, specialty, or retail pharmacies;

''(II) the percentage of total prescriptions dispensed by such pharmacies to participants or beneficiaries in such plan; and

''(III) a list of all drugs dispensed by such pharmacies to participants or beneficiaries enrolled in such plan, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan, and to participants and beneficiaries;

''(bb) the median amount charged to such plan, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan and to participants and beneficiaries, that is available from any pharmacy included in the network of such plan; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount; and

''(B) with respect to any group health plan, regardless of whether the plan is offered by a specified large employer or whether it is a specified large plan—

''(i) a summary document for the group health plan that includes such information described in clauses (i) through (iv) of subparagraph (A), as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking), that the Secretary determines useful to group health plans for purposes of selecting pharmacy benefit management services, such as an estimated net price to group health plan and participant or beneficiary, a cost per claim, the fee structure or reimbursement model, and estimated cost per participant or beneficiary;

''(ii) a summary document for plans to provide to participants and beneficiaries, which shall be made available to participants or beneficiaries upon request to their group health plan, that—

''(I) contains such information described in clauses (iii), (iv), (v), and (vi), as applicable, as specified by the Secretary through guidance, program instruction, or otherwise (with no requirement of notice and comment rulemaking) that the Secretary determines useful to participants or beneficiaries in better understanding the plan or benefits under such plan;

''(II) contains only aggregate information; and

''(III) states that participants and beneficiaries may request specific, claims-level information required to be furnished under subsection (c) from the group health plan;

''(iii) with respect to drugs covered by such plan during such reporting period—

''(I) the total net spending by the plan for all such drugs;

''(II) the total amount received, or expected to be received, by the plan from any applicable entity in rebates, fees, alternative discounts, or other remuneration; and

''(III) to the extent feasible, information on the total amount of remuneration for such drugs, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copayment assistance on behalf of such drug manufacturer) to participants and beneficiaries;

''(iv) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act (29 U.S.C. 1108(b)(2)(B)(ii)(dd)(AA))) to brokerage firms, brokers, consultants, advisors, or any other individual or firm, for—

''(I) the referral of the group health plan's business to an entity providing pharmacy benefit management services, including the identity of the recipient of such amounts;

''(II) consideration of the entity providing pharmacy benefit management services by the group health plan; or

''(III) the retention of the entity by the group health plan;

''(v) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in such plan to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(vi) total gross spending on all drugs under the plan during the reporting period.

''(3) OPT-IN FOR GROUP HEALTH INSURANCE COVERAGE OFFERED BY A SPECIFIED LARGE EMPLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In the case of group health insurance coverage offered in connection with a group health plan that is offered by a specified large employer or is a specified large plan, such group health plan may, on an annual basis, for plan years beginning on or after the date that is 30 months after the date of enactment of this section, elect to require an entity providing pharmacy benefit management services on behalf of the health insurance issuer to submit to such group health plan a report that includes all of the information described in paragraph (2)(A), in addition to the information described in paragraph (2)(B).

''(4) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan shall report information under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a group health plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—

''(i) Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) Nothing in this section shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, group health plans shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for entities providing pharmacy benefit management services on behalf of the group health plan to submit reports to group health plans under paragraph (1), as applicable, which may include incorporating such

notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent an entity providing pharmacy benefit management services on behalf of a group health plan, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan or entity may not—

''(i) restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury; or

''(ii) prevent disclosure for the purposes of subsection (c), or any other public disclosure requirement under this section.

''(G) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required with respect to any group health plan established by a plan sponsor that is, or is affiliated with, a drug manufacturer, drug wholesaler, or other direct participant in the drug supply chain, in order to prevent anticompetitive behavior.

''(5) STANDARD FORMAT AND REGULATIONS.—

''(A) IN GENERAL.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking a standard format for entities providing pharmacy benefit management services on behalf of group health plans, to submit reports required under paragraph (1).

''(B) ADDITIONAL REGULATIONS.—Not later than 18 months after the date of enactment of this section, the Secretary shall, through rulemaking, promulgate any other final regulations necessary to implement the requirements of this section. In promulgating such regulations, the Secretary shall, to the extent practicable, align the reporting requirements under this section with the reporting requirements under section 9825.

''(c) REQUIREMENT TO PROVIDE INFORMATION TO PARTICIPANTS OR BENEFICIARIES.—A group health plan, upon request of a participant or beneficiary, shall provide to such participant or beneficiary—

''(1) the summary document described in subsection (b)(2)(B)(ii); and

''(2) the information described in subsection (b)(2)(A)(i)(III) with respect to a claim made by or on behalf of such participant or beneficiary.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer, or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary to a report described in subsection (b)(1) or information related to compliance with subsections (a), (b), or (c) of this section or section 4980D(g) by such issuer, plan, or entity.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE ENTITY.—The term 'applicable entity' means—

''(A) an applicable group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator (or other purchasing entity designed to aggregate rebates), or associated third party;

''(B) any subsidiary, parent, affiliate, or subcontractor of a group health plan, health insurance issuer, entity that provides pharmacy benefit management services on behalf of such a plan or issuer, or any entity described in subparagraph (A); or

''(C) such other entity as the Secretary may specify through rulemaking.

''(2) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization that is affiliated with or under common ownership with an entity providing pharmacy benefit management services.

''(3) CONTRACTED COMPENSATION.—The term 'contracted compensation' means the sum of any ingredient cost and dispensing fee for a drug (inclusive of the out-of-pocket costs to the participant or beneficiary), or another analogous compensation structure that the Secretary may specify through regulations.

''(4) GROSS SPENDING.—The term 'gross spending', with respect to prescription drug benefits under a group health plan, means the amount spent by a group health plan on prescription drug benefits, calculated before the application of rebates, fees, alternative discounts, or other remuneration.

''(5) NET SPENDING.—The term 'net spending', with respect to prescription drug benefits under a group health plan, means the amount spent by a group health plan on prescription drug benefits, calculated after the application of rebates, fees, alternative discounts, or other remuneration.

''(6) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)).

''(7) REMUNERATION.—The term 'remuneration' has the meaning given such term by the Secretary, through rulemaking, which shall be reevaluated by the Secretary every 5 years.

''(8) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan established or maintained by a single employer, with respect to a calendar year or a plan year, as applicable, an employer who employed an average of at least 100 employees on business days during the preceding calendar year or plan year and who employs at least 1 employee on the first day of the calendar year or plan year.

''(9) SPECIFIED LARGE PLAN.—The term 'specified large plan' means a group health plan established or maintained by a plan sponsor described in clause (ii) or (iii) of section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(16)(B)) that had an average of at least 100 participants on business days during the preceding calendar year or plan year, as applicable.

''(10) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–3a(c)(6)(B)).''.

(2) EXCEPTION FOR CERTAIN GROUP HEALTH PLANS.—Section 9831(a)(2) of the Internal Revenue Code of 1986 is amended by inserting ''other than with respect to section 9826,'' before ''any group health plan''.

(3) ENFORCEMENT.—Section 4980D of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) APPLICATION TO REQUIREMENTS IMPOSED ON CERTAIN ENTITIES PROVIDING PHARMACY BENEFIT MANAGEMENT SERVICES.—In the case of any requirement under section 9826 that applies with respect to an entity providing pharmacy benefit management services on behalf of a group health plan, any reference in this section to such group health plan (and the reference in subsection (e)(1) to the employer) shall be treated as including a reference to such entity.''.

(4) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9826. Oversight of entities that provide pharmacy benefit management services.''.

SEC. 202. FUNDING COST SHARING REDUCTION PAYMENTS.

Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

''(h) FUNDING.—

''(1) IN GENERAL.—There are appropriated out of any monies in the Treasury not otherwise appropriated such sums as may be necessary for purposes of making payments under this section for plan years beginning on or after January 1, 2027.

''(2) LIMITATION.—

''(A) IN GENERAL.—The amounts appropriated under paragraph (1) may not be used for purposes of making payments under this section for a qualified health plan that provides health benefit coverage that includes coverage of abortion.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to payments for a qualified health plan that provides coverage of abortion only if necessary to save the life of the mother or if the pregnancy is a result of an act of rape or incest.''.

The SPEAKER pro tempore. The bill shall be debatable for 1 hour, equally divided and controlled by the chair and ranking minority member of the Committee on Education and Workforce or their respective designees, the chair and ranking member of the Committee on Energy and Commerce or their respective designees, and the chair and ranking member of the Committee on Ways and Means or their respective designees.

The gentleman from Michigan (Mr. WALBERG), the gentleman from Virginia (Mr. SCOTT), the gentleman from Kentucky (Mr. GUTHRIE), the gentleman from New Jersey (Mr. PALLONE), the gentleman from Missouri (Mr. SMITH), and the gentleman from Massachusetts (Mr. NEAL) shall each control 10 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on the legislation, H.R. 6703.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 6703, the Lower Health Care Premiums for All Americans Act.

When the Democrats passed ObamaCare over a decade ago, they sold the bill on the promise that it would lower healthcare costs and preserve plan options. If you like your plan, you can keep it and if you like your doctor, you can keep them, we remember being quoted. These famous last words still haunt us.

Today, we know that ObamaCare has not lived up to the Democrats' lofty promises. Instead, the consequences of that bill continue to burden American patients as they have since its enactment. Healthcare spending has nearly doubled since ObamaCare passed.

Healthcare plan options have been decimated by Democratic overreach, and millions of Americans are saddled with medical debt across the country.

ObamaCare premiums are up 80 percent since the program's inception, with patients paying on average $5,000 out of their own pocket to hit their deductible. The average out-of-pocket spending maximum for 1 year is over $20,000. Without a doubt, ObamaCare has proven to be unaffordable and unsustainable.

In an attempt to respond to the affordability crisis created by ObamaCare, Democrats leveraged a public health emergency to shovel hundreds of billions of dollars to big health insurance plans to mask the risk of rising unaffordability of coverage. First, in the American Rescue Plan of 2021 and then again in the Inflation Reduction Act of 2023, Democrats sent temporary taxpayer-funded enhanced premium tax credits directly to the coffers of big insurance plans.

They did this without a single Republican vote of support. On both occasions, Democrats chose to make these COVID credits temporary. They could have made them permanent, but they chose instead to focus on advancing priorities for wealthy Americans, which some of these they did make permanent by subsidizing electric vehicles for politically connected cronies to siphon off Federal dollars of the greenhouse gas slush fund.

Now, Democrats are uniting behind that policy to send billions more of taxpayer dollars to big health insurance plans. With the Democrats' temporary COVID credits set to expire at the end of the year, they are attempting to turn their policy failures into political gains using the American people as collateral.

It is worth reiterating. Democrats funded temporary Band-Aids to cover up unaffordable care. They set the expiration dates. They chose to fund liberal priorities instead of making them permanent.

While Democrats continue to fearmonger, I want to shed light on what Republicans are doing to fix the Democrats' affordability crisis, with policies that deliver real, lasting relief to the American people. These include eliminating health plan gimmicks like silver loading, which will lower ACA premiums by 11 percent; increasing transparency for pharmacy benefit managers, the middlemen that will lower costs of drugs for all Americans; and increasing affordable plan choices and putting patients back in the driver's seat for their own healthcare plan choices by instituting association health plans, CHOICE arrangements, and stop-loss insurance.

This proposal results in more than double the premium reduction that Democrats' extension of the enhanced tax credit subsidies would. The Congressional Budget Office estimates this plan will lower premiums by 11 percent compared to just 5 percent from the Democratic subsidies. These policies will also lower healthcare costs for all Americans, not just the roughly 7 percent enrolled in the ObamaCare marketplace. Many of these policies are bipartisan: Ending silver loading, addressing nefarious PBM practices, and strengthening the employer insurance marketplace all have garnered broad bipartisan support.

I hope we can overlook politics that are clouding the issue and come together to pass this bill and continue to work together in 2026 to deliver more affordable healthcare to all Americans.

Mr. Speaker, I reserve the balance of my time.

□ 1120

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise to call on Speaker JOHNSON to immediately bring the bipartisan 3-year extension of the Affordable Care Act tax credits to the floor. This bill now has the support, pursuant to a discharge petition, of a majority of House Members and should get a vote immediately before the ACA tax credits expire.

Mr. Speaker, without this tax credit extension bill by Mr. JEFFRIES, health insurance premiums are going to skyrocket for more than 20 million Americans across the country. They will see prices double, triple, and even quadruple. It will leave millions with the difficult decision of going without coverage because they simply cannot afford rising costs.

Just days before prices skyrocket for American families, Republicans are bringing a bill to the floor that does absolutely nothing to lower prices. Instead, Republicans are using this affordability crisis to prop up junk health insurance plans that discriminate against people and leave them hanging when they get sick.

Mr. Speaker, the American people are desperate for our help, and this Republican bill doesn't do a thing to provide it. This bill is a sham, and a majority of the House knows it.

I urge my colleagues to vote ''no.'' We should take real action immediately by passing the Jeffries bill.

Mr. Speaker, I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Iowa (Mrs. MILLER-MEEKS), the sponsor of this legislation.

Mrs. MILLER-MEEKS. Mr. Speaker, I rise today in strong support of my bill, the Lower Health Care Premiums for All Americans Act, a bill rightfully named because that is exactly what it does.

Republicans want to lower healthcare costs and premiums for all Americans, all the Americans on commercial insurance, all the small businesses, all the people on the ACA exchanges, and all the self-insured, not just a select few, and not subsidizing profitable insurance companies.

Insurance, especially bad insurance, is not care.

The Lower Health Care Premiums for All Americans Act offers commonsense solutions to America's broken healthcare system.

It lowers premiums through choice and competition. By expanding association health plans, we give small businesses and self-employed workers the buying power of large employers, cutting premiums by as much as 30 percent.

It gives families control over their dollars. We strengthen CHOICE arrangements, allowing defined contributions and pretax options so workers can choose the right plan for their needs, rather than being stuck in plans that cost too much and deliver too little care.

It brings transparency transparent to drug pricing. We take on the pharmacy benefit managers, which have long operated behind the scenes as middlemen, collecting hidden fees while prescription prices climb. Our reforms force transparency so families can finally see where their healthcare dollars go and pay less at the pharmacy counter.

It protects access to employer-sponsored insurance. By clarifying access to stop-loss insurance, we safeguard small businesses from being financially ruined by catastrophic health claims.

It stabilizes premiums responsibly. We responsibly fund cost-sharing reduction payments, lowering ACA premium costs for all in the marketplace by 11 percent. This policy alone results in an average premium savings of $900 nationally, while reducing Federal spending, saving taxpayers $36 billion.

Contrary to what we hear from my colleagues on the other side of the aisle, the premium tax credits continue and revert back to their 2021 levels.

This bill delivers what Americans have been asking for: lower premiums, more choices, and a healthcare system that works for them, not against them. It is time to put all Americans and their doctors in the driver's seat and ahead of profitable insurance companies.

Mr. Speaker, I urge my colleagues to support this legislation.

Mr. PALLONE. Mr. Speaker, before I yield time, I will make sure that the gentlewoman from Iowa knows that without the ACA tax credit extension, a middle-class 60-year-old couple in her district is seeing their premium go up by $1,422 per month.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Massachusetts (Ms. CLARK), the Democratic whip.

Ms. CLARK of Massachusetts. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, my question to the Republican Party is, what are you doing?

What are you doing? Why won't you use your immense powers as the majority to help the American people?

The bill before us does nothing for the 15 million Americans who are about to lose their health insurance, the 1 million children who are about to become uninsured, the hundreds of hospitals that are closing or on the verge of closing, or the 24 million people who are staring down premiums they simply cannot afford.

It does nothing to solve a crisis that the Republicans have inflicted on the American people, but, but, but, in typical fashion, here is what it does do. It does promote the GOP dream of a nationwide abortion ban.

You found time for that, but today is the day to stop these tax credits from expiring. You called us back in July from recess to make sure that we voted on tax cuts, to make them permanent for the very richest Americans, but now that we have a bipartisan discharge petition ready to vote on today, you can't find the time to do it.

We are ready to vote, Mr. Speaker. You have the power to bring that to the floor today.

Let the will of the people be the will of the people's House. Let's stop the premium hikes, extend the ACA tax credits, and get back to building a healthcare system that is worthy of the American people.

Mr. GUTHRIE. Mr. Speaker, I will remind my friends that the premium tax credits from the ACA are extended. They are permanent. These are the enhanced premium tax credits. It is good, and sad, that my colleagues are recognizing that the Affordable Care Act is failing.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. PFLUGER), my good friend and leader on the Energy and Commerce Committee.

Mr. PFLUGER. Mr. Speaker, I will remind my colleagues across the aisle that not a single Republican has ever voted for ObamaCare. This is your plan. You put it into law. It was a disaster then. It is a disaster now. It was more expensive now than it has ever been, and it is your plan. It is our job to fix it, which is exactly what we are doing.

Mr. Speaker, ObamaCare has failed to deliver on its promises. It has left millions of Americans with higher premiums. Again, your votes did that. It has fewer choices, less coverage, and is plagued by fraud, waste, and abuse.

Mr. Speaker, I recently had a constituent write to me, outlining her and her husband's experience, demonstrating systematic fraud within the ACA marketplace. Her husband has been repeatedly enrolled in an ACA plan without consent since November 2023 in a scheme where brokers and agents are fraudulently enrolling individuals to collect commissions and meet enrollment quotas. This broker gained unauthorized access to his prescription records and replaced his legitimate employer-sponsored insurance coverage at his pharmacy.

I wish I could say that these examples are one-time instances, but we know they are not. The system was built for this kind of fraud. They represent the broader failure that is ObamaCare.

We must take action to fix this broken system and make healthcare actually affordable, not the Ponzi scheme that it currently is.

The Lower Health Care Premiums for All Americans Act is a great first step toward this mission, and we will drive down health insurance premiums immediately by 11 percent through cost-sharing reduction payments, provide patients with greater transparency, and support small businesses that offer employment-based healthcare.

Mr. Speaker, we should do more as a Republican Conference, including creating Trump health freedom accounts and allowing Americans to shop across State lines, encouraging competition.

Not a single Republican ever voted for your plan, but we are fixing it now. This is a good first step.

Mr. PALLONE. Mr. Speaker, before I yield time, I will make sure that the gentleman from Texas knows that without the ACA tax credit extension, a middle-class 60-year-old couple in his district is seeing their premium go up by $2,049 per month.

Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. MATSUI).

□ 1130

Ms. MATSUI. Mr. Speaker, I rise today in opposition to this bill. This should be called the lower healthcare premiums for none act.

Next year, my constituent, Natalie's, insurance will go from $175 to $400 a month, a fifth of her monthly wages. She is a college student who relies on her insurance for mental health care. She wrote to me: I don't want to pick between my dream, mental health, and food.

What does this bill do for her? Nothing. I know Republicans are getting similar calls. Yet, instead of caring about the millions of Americans who are being forced to make impossible choices, they are putting up this sham of a bill. They should be ashamed.

Mr. Speaker, we came here to deliver for our constituents. Let's vote on a clean extension and avert the cliff. Let's put an end to this scam.

Mr. GUTHRIE. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, we have heard sad stories. Last night, in the Rules Committee, the Rules chairman read through different stuff. The Rules' ranking member was in townhalls and heard stories about people who had to buy care on the Affordable Care Act marketplace that is failing.

There is one thing nobody has ever answered. They say they have to face their constituents. Do my colleagues explain to their constituents that in the bill that they voted for that gave billions of dollars of the Green New Deal; in the same bill they set these tax cuts to expire?

I know it was during reconciliation they could have done them within 10 years instead of 5. They also could have done them permanently. There is a way in reconciliation to do them permanently, as well.

No one on the other side has ever explained why they chose to make these tax credits expire. I am still waiting to hear the answer for that.

In the meantime, we have our bill that will lower premiums, calculated by CBO, in the individual market by 11 percent, as opposed to the 5 percent that would happen if we just passed the enhanced tax credits. Not just the 7 percent in the ObamaCare marketplace will benefit but all Americans will benefit from this bill.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I want to make sure the chairman from Kentucky knows that a middle-class, 60-year-old couple in his district is seeing their premium go up by $1,711 per month unless we extend the ACA tax credits.

Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. CASTOR), the ranking member of the Subcommittee on Energy.

Ms. CASTOR of Florida. Mr. Speaker, I rise to oppose this Republican charade and to stand up for my neighbors back home who deserve quality and affordable health coverage. That includes over half a million of my hardworking neighbors across the Tampa Bay area.

Mr. Speaker, 4.7 Floridians, or one in five who live in the Sunshine State, are doing everything right. They are entrepreneurs. They are caregivers.

They are part-time workers and small business owners like Linda Misener and her husband. Their premiums will go from $288 per month to over $3,200 per month next year. They cannot afford $39,000 for their healthcare. They are terrified that they are going to lose everything.

David, who is being treated for pancreatic cancer, is unsure how he will continue treatments and afford everything else.

It is unconscionable that Republicans are ripping away coverage to fund their tax breaks for billionaires, the wealthy, and the well-connected. Americans deserve so much better.

Mr. Speaker, defeat this Republican bill. Bring the 3-year bipartisan extension to the floor now.

Mr. GUTHRIE. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I again ask the question: Why were these set to expire? We hear the stories that people are reading about people in their districts, and they say how it is unconscionable. It is unconscionable that money was spent on the Green New Deal at the expense of the enhanced tax credits they talk about.

We want to solve it. Mr. Speaker, $39,000 is what is brought up for

healthcare. That is the problem in America. Mr. Speaker, $39,000 for health insurance is what we have to fix.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. TONKO), the ranking member of our Subcommittee on Environment.

Mr. TONKO. Mr. Speaker, as a result, 4 million people will lose their insurance. Everyone else on an ACA plan will pay more for worse coverage, while billionaires sit comfortably and enjoy their tax breaks from the One Big Beautiful Bill Act.

Remember in the summer and fall, when Republicans told us that this wasn't the right time to negotiate these subsidies over the shutdown, they said: Don't worry. That doesn't expire until later in the year. We are working on a plan.

Later is here. What does this Republican plan do to extend the ACA subsidies? It does nothing. It does absolutely nothing. This is unacceptable and downright cruel. While I am disappointed that Republicans refuse to extend this lifeline, I am not surprised. They had no intention of voting on extending ACA subsidies.

In fact, I heard that Republican leadership told my fellow New York Republicans that they needed to find a way to pay for the ACA subsidy extension if they wanted to even have a vote on it.

Playing under the Republicans' new rules, shouldn't this be free, or does that math only apply for their billionaire buddies and their tax breaks?

Mr. Speaker, I urge every Member who cares about their constituents having affordable healthcare to oppose this plan and sign Leader JEFFRIES' petition. Do it for the people.

Mr. GUTHRIE. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. BARRAGÁN), a member of our committee.

Ms. BARRAGÁN. Mr. Speaker, Americans should run away as far and as fast as they can from Republicans' last-minute mess of a healthcare plan.

Under the Republicans' plan, millions of Americans will not be able to afford health insurance because Republicans don't provide money for Americans to pay for the healthcare under the Affordable Care Act.

Americans don't have an extra $1,000 or $2,000 in their pockets every month to pay for health insurance. They shouldn't have to choose between being able to afford a doctor's visit or feeding their family.

House Democrats' discharge petition will extend the tax credits that lower costs and help Americans buy health insurance. Mr. Speaker, four Republicans just joined our efforts. We welcome more.

Speaker JOHNSON should bring the bill to the floor immediately. Don't send Congress on holiday without making sure that we protect healthcare for over 20 million Americans.

Mr. GUTHRIE. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Massachusetts (Mrs. TRAHAN), also a member of our committee.

Mrs. TRAHAN. Mr. Speaker, this vote is a waste of time. Nothing in this Republican healthcare plan will stop Americans' healthcare premiums from skyrocketing.

When this bill fails to become law—and it will fail—20 million Americans will see their premiums surge on January 1. Many will not even be able to afford hundreds or even thousands more each month, they will lose their healthcare coverage completely.

This is a partisan exercise that does nothing to address the crisis before us. That is why, moments ago, four Republicans signed onto the bipartisan legislation to end this crisis and protect Americans' healthcare, giving it the signatures necessary to be considered on the House floor. The American people expect us to act with urgency, decisiveness, and transparency.

Mr. Speaker, cancel this vote. Call up the bipartisan bill to save Americans' healthcare before you take another vacation.

Mr. GUTHRIE. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, may I inquire as to how much time is remaining.

The SPEAKER pro tempore. The gentleman from New Jersey has 1 minute remaining. The gentleman from Kentucky has 15 seconds remaining.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Mrs. FLETCHER), the vice ranking member of the Energy and Commerce Committee.

Mrs. FLETCHER. Mr. Speaker, I rise in opposition to the disingenuously named Lower Healthcare Premiums for All Americans Act, which does not, in fact, lower healthcare premiums for all Americans.

In response to political pressure from the very real healthcare crisis before us, House Republicans have rushed this bill to the floor without input from House Democrats and without going through the Energy and Commerce Committee, as it should, or any actual legislative process.

That might sound like it is in the weeds, but it is not. It is a glaring failure to engage in real and meaningful policy that the country is demanding. It is a response to the crisis that this Republican Congress has created with the cuts it made earlier this year and its failure to extend the premium tax credits, which we can fix today. It is another example of this Congress failing to do its real work.

We have to see the big picture here. Congress isn't working as it should. Speaker JOHNSON and House Republicans are pushing this bill on the floor to address a political crisis, not the healthcare crisis.

If House Republicans were serious, this bill would actually do something to lower costs. Instead, the experts tell us this bill will do nothing to decrease costs for Americans and nothing to curb junk plans, but it does have a backdoor ban on abortion for people on ACA plans.

The SPEAKER pro tempore. The time of the gentleman from New Jersey (Mr. PALLONE) has expired.

Mr. GUTHRIE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, we are here to solve the problem for all Americans. Mr. Speaker, 20 million people are trapped in the Affordable Care Act marketplace. Our proposal lowers those premiums by 11 percent.

There are over 160 million Americans who get it through their employers. There are Americans on other types of health insurance. We need to fix this problem.

My good friend from Florida, Mr. Speaker, said $39,000 is what they pay for health insurance. That is the problem. That is what we need to fix.

Mr. Speaker, I yield back the balance of my time.

□ 1140

The SPEAKER pro tempore. The gentleman from Missouri (Mr. SMITH) and the gentleman from Massachusetts (Mr. NEAL) will each control 10 minutes.

The Chair recognizes the gentleman from Missouri.

Mr. SMITH of Missouri. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, when it comes to healthcare, Republicans are focused on lowering costs and expanding choice for all Americans. That is 347 million people, not just 7 percent of the population, which is all you are going to hear from the other side of the aisle, and that is all you have been hearing from the other side of the aisle.

Mr. Speaker, for more than a decade, Democrats have promised that ObamaCare would lower costs. They actually named the bill the ''Affordable Care Act.'' Find one American—find one American who says that their healthcare is now cheaper today than it was when they passed this disastrous bill. You won't. You won't find one.

In fact, the sky is falling because of their enhanced premium tax credits that they made temporary because they decided to make permanent tax benefits for wealthy environmentalists who support them. That is why we are where we are today.

Mr. Speaker, since ObamaCare has passed, we have seen 150-plus hospitals close their doors. Since ObamaCare has passed, we have seen premiums go up more than 80 percent. It doesn't sound like the Affordable Care Act by any means.

Even worse, the Government Accountability Office has confirmed what Republicans have been warning for years: ObamaCare is riddled with

waste, fraud, and abuse. The GAO led a covert investigation by creating fictitious ObamaCare applicants with fake documentation where 100 percent of those applicants were accepted and enrolled.

Guess what? A year later, this year, of that 100 percent, 90 percent were still receiving subsidies. That means that insurance companies were still being subsidized for fake accounts where the people didn't even exist.

Data analysis from GAO also finds that 58,000-plus enrollees matched Social Security numbers with death records, with 7,000 of them dead before enrollment even began. There were dead people on the rolls, but what do they want to do? Their answer is to just continue the same old-same old by extending the current program with no reforms.

Mr. Speaker, one Social Security number alone had more than 125 different policies attached to it—just one. This all came from the GAO. This didn't come from the House Republicans.

We should not continue propping up a system that has completely failed to lower costs for Americans. The Lower Healthcare Premiums for All Americans Act takes a much different approach. It is one that delivers real relief.

First, it provides more freedom and flexibility through CHOICE Arrangements, empowering small businesses to offer tax-free benefits so that their employees can find health coverage that works for them.

This levels the playing field for small businesses, putting them on equal footing with large employers when competing for workers. These arrangements are proven to be successful. In fact, 83 percent of employers using CHOICE Arrangements are offering coverage for the very first time.

The bill also brings transparency to pharmacy benefit managers, requiring them to open up the books to finally give employers the data that they need to increase competition and negotiate better drug prices for workers. The result: Healthcare costs and premiums will be lowered for all—for all Americans, not just the 7 percent that the Democrats are fighting for in the enhanced COVID-era premium tax credits, but also for the 300 million-plus Americans.

Mr. Speaker, ObamaCare has driven costs up and choice down. This bill does the complete opposite.

Mr. Speaker, I urge my colleagues to support the Lower Healthcare Premiums for All Americans Act and stand with families, workers, and small businesses who deserve—they deserve a real affordable, accountable healthcare plan.

Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Republican bill was put together with bubble gum and Elmer's glue last Friday night. This isn't a plan. It sounds like their argument that 300-year-olds are receiving Social Security benefits.

Families are staring at massive premium hikes, and now, thanks to four Republicans, we can force a vote. When you listen to the argument earlier from the gentleman from Texas (Mr. PFLUGER), he said that Republicans never had a chance to vote on the Affordable Care Act. This morning, we want to give you a chance.

Speaker JOHNSON could end this crisis and bring the bill up. Instead, they are wasting time on this dusty bill that will increase the number of uninsured Americans, and that is a fact. People don't need healthcare that costs more and covers less. To stave off this crisis, this bipartisan discharge petition is a workable path forward, and over the course of the next few minutes, we intend to tell you that you can hear why.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of Missouri. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. ARRINGTON), the chairman of the Budget Committee.

Mr. ARRINGTON. Mr. Speaker, let me simplify the debate today for the American people.

Republicans are bringing forward reforms that will actually lower the cost of care. According to CBO, which is the gold standard for my Democratic colleagues, it will reduce premiums by 11 percent.

Mr. Speaker, the only other time premiums have gone down since ObamaCare was enacted was when Republicans actually advanced reforms in the One Big Beautiful Bill Act; namely, rooting out waste, fraud, and abuse. That lowered the cost of care.

We continue to bail out the unaffordable care act and actually make it more affordable, along with other policies that provide the Federal assistance to the people, not insurance agencies, and give the private market more competition and transparency so that people have more choice. That is our plan, and it lowers costs for everybody.

The Democrats are trying to put forward an extension of a COVID-era, fraud-ridden subsidy that has proven time and again—GAO, CBO, all the watchdogs say it is fraught with tens of billions of dollars of fraud. Tens of thousands of Social Security numbers from dead people have been used to siphon money away from this program.

Millions of people, according to CBO, are ineligibly on the program, and the answer from the Democrats is to perpetuate this fraud bag, which is a completely egregious and reckless thing to do as stewards of tax dollars. This is not to mention that it is propping up the underlying program that, year after year, has raised premiums and deductibles two times—it has doubled premiums and deductibles since ObamaCare has been enacted.

We have fewer choices. Things are worse.

As Ronald Reagan said so beautifully, so aptly, in this moment, I can't think of any better words: ''Government is not the solution . . .'' here. Democrats all have proven that. ''Government is the problem,'' and we have the solution that actually delivers the affordability to the American people.

Mr. Speaker, I urge my colleagues to support it.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from California (Mr. THOMPSON).

□ 1150

Mr. THOMPSON of California. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise to call for a vote immediately to save America's healthcare.

Across our country, American families are being squeezed by high grocery prices, high utility bills, and soaring costs for holiday gifts. Families can't afford to pay double for their healthcare. Republicans cut $1 trillion from healthcare to give a tax break to their billionaire donors. Americans of every party stripe are being hurt, and they have had enough.

This morning, four Republicans joined every Democrat to sign a petition forcing you to hold a vote on our bill that will save healthcare for 4 million people. Mr. Speaker, it is your turn to act. Hold the vote to save healthcare now.

It is important to point out that the CBO analysis that my Republican friends keep talking about says that it is going to cost 100,000 people more every year for healthcare.

Hold the vote on the bill that will save healthcare.

The SPEAKER pro tempore. Members are reminded to direct their remarks to the Chair.

Mr. SMITH of Missouri. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. HERN).

Mr. HERN of Oklahoma. Mr. Speaker, I am pleased this bill is coming to the floor today.

Every patient's health needs are unique, and every person's situation is different. This is why it is so important to expand and protect the different options available to individuals, and this bill does exactly that. It gives the decisionmaking process back to the American people.

I am honored that this package includes my bill, the CHOICE Arrangement Act, which makes it easier for small businesses—something that I know something about after 35 years in business—to offer healthcare coverage. It gives individuals more options to choose health plans that work for them.

CHOICE accounts put individuals in the driver's seat when it comes to picking their healthcare plan and lets their employer financially support their decision. This empowers people in one of their most personal decisions, their healthcare.

Over the last 15 years, healthcare has become unaffordable for everyone, including 164 million Americans covered by employer-sponsored plans. Yet, my colleagues on the other side of the aisle continue to ignore these individuals in their healthcare conversations.

The gentleman from California just stated, ''This is for 4 million,'' what they are talking about. We want to lower the healthcare costs for over 300 million people in America.

Premiums are rising for all Americans, whether you are on the exchange or an employer-sponsored plan, whether you are a Democrat or a Republican, whether you are healthy or you are unhealthy.

We should be focused on making healthcare affordable for all Americans and include those on the exchange, employer-sponsored plans, Medicare, and Medicaid.

The provisions of this bill are a start to doing so by giving Americans what they need: lower costs, more choices, and increased transparency.

Mr. Speaker, I strongly urge my colleagues to vote ''yes.''

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from Connecticut (Mr. LARSON).

Mr. LARSON of Connecticut. Mr. Speaker, I thank Mr. NEAL for the time.

Mr. Speaker, a constituent in my district in Middletown is going to be paying more for health insurance than he does for his mortgage.

Let's cut right to the chase. This is about a vote for the American people. This great democracy that we live in, this Chamber that could once actually discuss and debate issues, Speaker JOHNSON should be bringing this bill to the floor today.

Do Republicans have the courage to vote, or are they going to run and hide? Four Republicans have stood up and said: You know what, in a democracy, this deserves a vote.

Listen carefully, American people, how they decry this bill, yet they won't even have a vote.

Mr. SMITH of Missouri. Mr. Speaker, may I inquire as to how much time I have remaining.

The SPEAKER pro tempore. The gentleman from Missouri has 1 minute and 15 seconds remaining.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, I got this note this morning from a constituent of mine who said: ''Dear Congressman Davis, I wish you were voting to extend the tax credits for healthcare today. I am a single mother with a daughter in college. Without these Federal tax credits, we will be in an extremely vulnerable position. Accessing healthcare would be virtually impossible, and the stability of our lives would be at serious risk. These tax credits are not just helpful. They are essential. I don't know what we would do without them.''

Mr. Speaker, I agree with Shameka.

Mr. SMITH of Missouri. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. MILLER).

Mr. MILLER of Ohio. Mr. Speaker, Ohio families and small businesses continue to face unprecedented healthcare costs, making it increasingly difficult for my constituents to access affordable, high-quality care.

Since the enactment of the so-called Affordable Care Act in 2010, healthcare costs have risen dramatically, with premiums increasing by more than 25 percent over the last 5 years. This trend makes clear that our Nation's healthcare system needs reform to lower costs for patients and ensure stability for providers.

The Lower Health Care Premiums for All Americans Act is a critical step forward in curbing rising premiums, expanding choice, and improving transparency. The legislation includes provisions to improve affordability, particularly for small businesses, along with cost-sharing reduction funding and PBM reforms.

As we move toward these goals, I urge the adoption of the Lower Health Care Premiums for All Americans Act and remain committed to reforming a broken healthcare system, increasing choice and competition to lower healthcare costs for our Nation.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentlewoman from Alabama (Ms. SEWELL).

Ms. SEWELL. Mr. Speaker, I rise today in strong opposition to this bill.

In a matter of days, roughly 130,000 people in my home State of Alabama will lose their healthcare coverage because Republicans in this body refuse to extend the ACA tax credits. Millions of Americans will find themselves one diagnosis away from bankruptcy.

Rather than addressing the crisis that they created, Republicans are pushing legislation that will make matters worse. Not only does this bill fail to extend the tax credits, but it promotes junk insurance plans that will rip off consumers and make healthcare even more unaffordable.

House Republicans are incapable of dealing with our Nation's affordability crisis. They should stop their political games and put the bipartisan JEFFRIES bills on the floor today.

Mr. Speaker, we deserve better. My constituents deserve better. Every American deserves better.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentlewoman from California (Ms. CHU).

Ms. CHU. Mr. Speaker, in 2 weeks, 22 million Americans will see their health insurance premiums skyrocket, not by accident, but because Republicans refuse to extend ACA tax credits that keep care affordable.

After 15 years, this is the Republican healthcare plan: higher costs, weaker coverage, and recycled ACA sabotage. Millions will pay hundreds or thousands of dollars more, and millions could lose coverage altogether.

Democrats have a solution right now and have the 218 bipartisan signatures for a clean bill to extend these tax credits. Speaker JOHNSON must put this bill on the floor now. The consequences are real. The American people are watching.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentlewoman from Wisconsin (Ms. MOORE).

Ms. MOORE of Wisconsin. Mr. Speaker, I thank Mr. NEAL for the time.

Mr. Speaker, time is up. The ACA tax credits are expiring December 31.

The ACA premium tax credits have provided healthcare access for 15 years to over 20 million people who were previously uninsured. The ACA has saved lives, but time is up. America can't wait another 15 years for Republicans to offer a real healthcare proposal that provides full coverage to all Americans.

''Lowering healthcare costs'' may be in the title, but it is nowhere in this proposal today.

I know that my own Senator, RON JOHNSON, a millionaire, has told me he would be just fine reverting to the pre-ACA world of high-risk pools and plans with limited benefits. This bill carries us back to a time when millions have an insurance card in their wallets that covers little to nothing.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Ms. MOORE of Wisconsin. The one big, beautiful bill transferred healthcare dollars—

The SPEAKER pro tempore. The gentlewoman is out of order. Her time has expired.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. JEFFRIES), the minority leader, who has done a terrific job on managing this legislation.

□ 1200

Mr. JEFFRIES. Mr. Speaker, let me first thank RICHARD NEAL, the once and future chairman of the powerful Ways and Means Committee, as well as FRANK PALLONE, BOBBY SCOTT, all my colleagues in government on the Democratic side, and the Republicans who have joined us now to make sure that we extend the Affordable Care Act tax credits which are scheduled to expire at the end of this month.

For months now, Democrats have made clear that we have a broken healthcare system that Republicans continue to destroy. They have exacerbated our healthcare crisis month after month after month, including with the one big, ugly bill, with the largest cut to Medicaid in American history, ripping healthcare away from 14 million Americans.

Hospitals, nursing homes, and community-based health centers are closing all across the country, including in rural America because of the Republican healthcare crisis.

Republicans, Mr. Speaker, continue to attack the National Institutes of Health, the Centers for Disease Control, the FDA, and vaccine availability.

Republicans have launched an all-out assault on the healthcare of the American people, and it continues today with this toxic piece of legislation that will rip healthcare away from an additional 4 million people and jam junk health insurance plans down the throats of the American people.

Democrats are strongly opposed to this legislation, and the American people know Republicans have zero credibility on fighting to protect their healthcare.

In this great country of ours, the wealthiest country in the history of the world, it should be the case, we believe, that access to high-quality healthcare should not simply be a privilege available only to the wealthy, the well-off, and the well-connected. Access to high-quality healthcare should be a right available to every single American. That is what House Democrats are continuing to fight hard to achieve.

One of the ways we can make sure that we strive to achieve that principle is to extend the Affordable Care Act tax credits, which are scheduled to expire in 15 days. That means that tens of millions of Americans, working-class Americans, middle-class Americans, people in urban America, rural America, small-town America, suburban America, the heartland of America, Black and Brown communities all throughout America, tens of millions of people, Americans of every stripe, in every region, are about to experience their health insurance premiums increase in some instances by $1,000 or $2,000 per month. That is unacceptable.

Now, we have a bipartisan coalition here in the House of Representatives, at least 218 votes, to extend the Affordable Care Act tax credits for 3 years, to provide everyday Americans with the certainty they deserve in terms of being able to afford to go see a doctor when they need one.

Mr. Speaker, Republicans need to bring the Affordable Care Act tax credit extension bill to the floor today. Under no circumstances should we leave this Capitol this week before voting on an extension of the Affordable Care Act tax credit bill that we know will pass, that the votes exist, in a bipartisan way, to protect the healthcare of everyday Americans.

House Democrats have made clear we are in this fight until we win this fight, to cancel the cuts, lower the costs, save healthcare, and extend the Affordable Care Act tax credits.

Mr. SMITH of Missouri. Mr. Speaker, I include in the RECORD the bombshell GAO report showing the waste, fraud, and abuse within the ObamaCare exchanges.

GAO, U.S. GOVERNMENT ACCOUNTABILITY OFFICE,
Washington, DC, December 3, 2025.

Hon. BRETT GUTHRIE,
Chairman, Committee on Energy and Commerce, House of Representatives.
Hon. JIM JORDAN,
Chairman, Committee on the Judiciary, House of Representatives.
Hon. JASON SMITH,
Chairman, Committee on Ways and Means, House of Representatives.

PATIENT PROTECTION AND AFFORDABLE CARE ACT: PRELIMINARY RESULTS FROM ONGOING REVIEW SUGGEST FRAUD RISKS IN THE ADVANCE PREMIUM TAX CREDIT PERSIST

The Patient Protection and Affordable Care Act (PPACA) provides premium tax credits to those who purchase private health insurance plans and meet certain income and other requirements. Individuals may have the federal government pay this credit to their health insurance issuers in advance on their behalf, known as the advance premium tax credit (APTC), which lowers their monthly premium payments.

Millions of consumers have purchased health insurance plans through the marketplaces established under PPACA. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for maintaining the federal Marketplace and overseeing state-based marketplaces. Under PPACA, states may elect to operate their own state-based marketplace or to use the federal Marketplace. These marketplaces determine eligibility for APTC, based in part on income, and allow individuals to compare and choose among insurance plans offered by participating private health care coverage issuers. CMS estimated it paid nearly $124 billion in APTC for about 19.5 million enrollees for plan year 2024.

Consumers can enroll in health insurance coverage through a marketplace independently or with assistance, such as from an insurance agent or broker. As discussed later in this report, agents and brokers can help a consumer apply for coverage, including for related financial assistance, and enroll in a plan. Assistance from an agent or broker is of no cost to a consumer. Rather, agents and brokers are allowed to receive compensation directly from health insurance issuers in accordance with agreements with those issuers and any applicable state requirements.

Indictments from December 2024 and February 2025 highlight concerns about agent and broker practices in the federal Marketplace. Specifically, the indictments allege that bad actors enrolled consumers in insurance through the federal Marketplace by falsifying information on their applications. Additionally, according to CMS, the agency received approximately 275,000 complaints between January and August 2024 that consumers were enrolled in a plan or had their plan changed without their consent. Such practices can result in wasteful federal spending on APTC for enrollees who are not eligible. Further, such practices can result in harm and unexpected costs for consumers. These can include loss of access to medical providers and medications, higher copayments and deductibles, or repayment of APTC if income or other eligibility was misrepresented.

We previously reported that APTC is at risk of fraud. For example, in September 2016, we found that federal and state marketplaces approved coverage for our fictitious applicants. Nearly all of these fictitious applicants remained covered after we sent fictitious documents or no documents to resolve issues with our applications. Further, in July 2017, we found that CMS did not design processes to verify eligibility for APTC, including preventing duplicate coverage.

You asked us to review issues related to fraud risk management in APTC. This report is based on preliminary results and analyses from that ongoing work. Specifically. this report addresses preliminary results from our

1. covert testing of federal Marketplace enrollment controls'for plan years 2024 and 2025,
2. analyses of federal Marketplace enrollment data for plan years 2023 and 2024, and
3. evaluation of CMS's fraud risk assessment and antifraud strategy for APTC.

To perform covert testing of federal Marketplace enrollment controls, we created 20 fictitious identities and submitted applications for individual health care coverage in the federal Marketplace. We submitted applications for four of these fictitious identities in October 2024 for coverage through December 2024, which was the remainder of that plan year. We pursued coverage for plan year 2025 for all 20 fictitious identities, including the four identities for which we already submitted applications. Our covert testing for plan year 2025 is ongoing, since the plan year is not yet complete. As a result, we will describe additional details of the 2025 applications in a future report.

Our covert testing included applications submitted independently through HealthCare.gov, which is the federal Marketplace's website, and applications submitted with assistance from an insurance agent or broker. For all our applicant scenarios, we sought to act as an ordinary consumer would in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

For applications for plan year 2024, our covert tests included fictitious applicants who provided invalid (i.e., never issued) Social Security numbers (SSN). Additionally, we stated income at a level eligible to obtain APTC. As appropriate, we used publicly available information to construct our applications for coverage and subsidies. We also used publicly available hardware, software, and materials to produce counterfeit documents that we submitted, if appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation. The results of our covert testing, while illustrative of potential enrollment control weaknesses, cannot be generalized to the overall enrollment population.

To examine federal Marketplace enrollment for plan years 2023 and 2024, we obtained and analyzed federal Marketplace enrollment and payment data, including APTC information, from CMS. We also matched enrollee SSNs in the data to two additional data sources: (1) Social Security Administration's (SSA) full death file, a database containing records of death that have been reported to SSA, as of November 2024 and (2) April 2025 data from the Internal Revenue Service (IRS) on APTC reconciliation from tax forms filed for tax year 2023. We assessed the reliability of all data sets by performing electronic tests to determine the completeness and accuracy of key fields. We also reviewed agency documentation and interviewed knowledgeable agency officials about the reliability of the data. Overall, we found that the data were reliable for our purposes.

To examine CMS's fraud risk assessment and antifraud strategy for APTC, we reviewed documentation of CMS's policies and fraud risk management activities related to APTC. This included CMS's 2018 fraud risk

assessment for APTC. Additionally, we interviewed agency officials about CMS's fraud risk management activities in this program. We reviewed relevant reports from GAO and HHS's Office of the Inspector General. We evaluated information from relevant documentation and interviews of agency officials against relevant leading practices in GAO's A Framework for Managing Fraud Risks in Federal Programs (Fraud Risk Framework).

To support all three objectives, we interviewed CMS officials and representatives from seven stakeholder organizations that represent agents and brokers, state insurance regulators, researchers, and one of the entities that CMS approved to host a nonmarketplace website where consumers can apply for and enroll in a plan offered through the federal Marketplace.

The ongoing work upon which this report is based is being conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our preliminary findings and conclusions based on our audit objectives. Additionally, our related investigative work is being conducted in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

APTC Eligibility and Enrollment Processes

APTC Eligibility

To qualify for a premium tax credit, individuals must be enrolled in a qualified health plan offered through a marketplace and meet certain criteria. These tax credits can be paid in advance through APTC. See figure 1 for the APTC eligibility requirements.

The amount of the premium tax credit varies based on household income and the cost of a benchmark plan. The credit limits what the consumer would pay for that plan to be no more than a certain percentage of their household income. The American Rescue Plan Act of 2021 made temporary changes to premium tax credits by expanding eligibility to higher-income individuals and increasing premium tax credits for lower-income individuals for tax years 2021 and 2022. For example, the law increased the premium tax credit amounts for eligible individuals and families, resulting in access to plans with no premium contributions for those earning 100 to 150 percent of the federal poverty level. It also expanded eligibility for premium tax credits to include certain individuals and families with incomes at or above 400 percent of the federal poverty level. Public Law 117–169—commonly known as the Inflation Reduction Act of 2022—extended these provisions through the end of tax year 2025. See table 1.

In 2013, CMS developed the Data Services Hub (Hub) to help verify applicant eligibility in an automated manner. To do so, the Hub matches applicant information, such as SSN and estimated income, against trusted data sources. These sources include records from SSA and IRS. In the federal Marketplace, the system generates an inconsistency when data matching processes are not able to verify applicant information against the Hub's trusted sources. When an inconsistency is generated, applicants are instructed to provide documentation to support information on their applications that cannot be verified by the Hub's data matching.

Marketplaces and Enrollment Pathways

States, along with the District of Columbia, may elect to rely on the federal Marketplace or operate their own health insurance marketplace. Table 2 describes the types of health insurance marketplaces.

The federal Marketplace offers multiple pathways to enroll in health insurance coverage and receive APTC. Consumers in states that use the federal Marketplace may enroll in coverage through the pathway known as HealthCare.gov or an enhanced direct enrollment (EDE) pathway, among others. Table 3 describes examples of enrollment pathways in the federal Marketplace.

Role of Agents and Brokers

Consumers seeking to obtain health insurance through the federal Marketplace may receive assistance from agents and brokers who help them apply for coverage, including related financial assistance, and enroll in a health plan. In return, agents and brokers receive payment (commissions or salaries) from the issuers of the health plans. Agents and brokers must be licensed in the state in which they sell plans and registered with CMS to sell plans through the federal Marketplace. According to CMS, most enrollments in the federal Marketplace are assisted by an agent or broker through the EDE and direct enrollment pathways.

CMS is responsible for oversight of agents and brokers in the federal Marketplace and ensuring that they comply with federal rules. Agents and brokers are required to, among other things, obtain and document consumers' consent before assisting them with applying for and enrolling in coverage through the federal Marketplace. For example, consumer consent is required before the agent or broker can:

collect or use any personally identifiable information, such as name, date of birth, and SSN;

help a consumer apply for coverage or financial assistance by completing an eligibility application on their behalf; and

actively enroll a consumer in a plan offered through the federal Marketplace.

After a consumer has applied or is enrolled, the agent or broker can also update a consumer's eligibility application or plan selection on their behalf, if the initial consent authorized the agent or broker to do so, or if they obtained subsequent consent for any new actions. Agents and brokers are required to make documentation of consumer consent available to CMS upon request in response to monitoring, audit, and enforcement actions.

Fraud Risk Management

The objective of fraud risk management is to ensure program integrity by continuously and strategically mitigating both the likelihood and effects of fraud, while also facilitating a program's mission. The Fraud Risk Framework provides a comprehensive set of leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based manner. As depicted in figure 2, the framework organizes the leading practices within four components: (1) Commit, (2) Assess, (3) Design and Implement, and (4) Evaluate and Adapt.

In June 2016, the Fraud Reduction and Data Analytics Act of 2015 (FRDAA) required the Office of Management and Budget (OMB) to establish guidelines for federal agencies to create controls to identify and assess fraud risks to design and implement antifraud control activities. The act further required OMB to incorporate the leading practices from the Fraud Risk Framework in the guidelines. The Payment Integrity Information Act of 2019 repealed FRDAA but maintained the requirement for OMB to provide guidelines to agencies in implementing the Fraud Risk Framework.

In its 2016 Circular No. A–123 guidelines, OMB directed agencies to adhere to, the Fraud Risk Frameworks leading practices. In October 2022, OMB issued a Controller Alert reminding agencies that they must establish financial and administrative controls to identify and assess fraud risks. In addition, the alert reminded agencies that they should adhere to the leading practices in the Fraud Risk Framework as part of their efforts to effectively design, implement, and operate an internal control system that addresses fraud risks.

The Federal Marketplace Approved Subsidized Coverage for Nearly All of Our Fictitious Applicants in Plan Years 2024 and 2025, Suggesting Weaknesses Persist

Our convert testing of enrollment controls in the federal Marketplace suggests weaknesses have persisted since our tests in plan years 2015 through 2016. All four of our fictitious applications received subsidized coverage through the federal Marketplace in late 2024. Additionally, although our work is ongoing, as of September 2025 18 of our 20 fictitious applications for plan year 2025 were receiving subsidized coverage. We will continue to monitor the status of these applications during plan year 2025.

All Four of Our Fictitious Applicants Received Subsidized Coverage in Late 2024

To test enrollment controls, we developed and submitted four fictitious applications to obtain insurance coverage with APTC through the federal Marketplace. We applied for coverage for these four applicants in October 2024. We submitted the applications outside of the open enrollment period, using a special enrollment period for low-income applicants. in two cases, we applied for coverage directly through HealthCare.gov. In the other two cases, we applied via telephone with assistance from an insurance broker. The brokers that assisted us used EDE systems to submit our applications.

The federal Marketplace approved fully subsidized insurance coverage for all four of our fictitious applicants for November through December 2024. The combined total amount of APTC paid to insurance companies for all four fictitious enrollees was about $2,350 per month. While our fictitious enrollees are not generalizable to the universe of enrollees, they suggest weaknesses in enrollment controls—such as identity proofing and income verification—in the federal Marketplace through both HealthCare.gov and EDE systems. Table 4 summarizes the results of our covert testing of enrollment controls for plan year 2024.

The results of our covert testing for plan year 2024 are generally consistent with results of similar testing we conducted for plan years 2014 through 2016.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from Virginia (Mr. BEYER).

Mr. BEYER. Mr. Speaker, earlier this year, House Republicans passed a bill that strips healthcare from millions of Americans and raises costs for millions more.

That was a monstrous bill, but this is a cowardly bill. It does nothing to stop the skyrocketing costs that we have been warning about for months. Nothing in this bill will extend the tax credits that help 20 million Americans afford health insurance.

This bill won't stop the Republican cuts that will raise my constituents' costs by $900 a month or restore coverage to millions whose coverage was sacrificed to give billionaires tax cuts.

The developed countries around the world have figured out how to give affordable healthcare to their citizens.

A vote for this bill is a vote for the Republican healthcare crisis.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from Illinois (Mr. SCHNEIDER).

Mr. SCHNEIDER. Mr. Speaker, my Republican colleagues are saying we are seeing inflation. Inflation in healthcare has been going on for generations. In fact, during the years of the George W. Bush administration, premiums increased 118 percent.

The Republican-led legislation they are presenting to us today is barely even a concept of a healthcare plan. After 15 years of efforts, they should be embarrassed by this slapdash effort.

Not only does the bill not address the expiring tax credits, it hurts patients, it hurts families, and it hurts women and seniors.

I want to be very clear. My Republican colleagues are taking zero action to extend the tax subsidies that help American families provide insurance to their families.

We need to do better. We can vote today on a clean 3-year extension because we have Republicans who have joined Democrats to call for that.

Mr. Speaker, I urge my colleagues to support the 3-year extension.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from California (Mr. PANETTA).

Mr. PANETTA. Mr. Speaker, if we don't extend the tax credits for the Affordable Care Act, costs for healthcare will go up for 20 million people and millions more will lose their health insurance.

Three-quarters of those who rely on those tax credits live in Republican-won States. Yet Speaker JOHNSON and President Trump, who are in charge and had all year to do anything, to do something, on healthcare, did nothing.

Rather than fulfill the President's promise to reduce prices, they gave tax breaks to billionaires, they gutted Medicaid, and they added trillions to our debt.

I get that division and dysfunction define the Republican Party, but we can't keep letting it define Congress. Put the Democratic discharge petition on the floor, extend the tax credits, so that together we can actually do something to fix healthcare. By doing that, we do our job, not just in Congress but for all Americans.

Mr. SMITH of Missouri. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 45 seconds to the gentleman from Nevada (Mr. HORSFORD).

Mr. HORSFORD. Mr. Speaker, after 15 years of talk, House Republicans have finally brought their healthcare bill to the floor, yet it fails working families. Despite its name, it does nothing to lower costs.

Republicans found time to lock in tax breaks for big corporations and billionaires but not the urgency or respect to help Americans afford their healthcare.

House Democrats are 100 percent united, and now four Republicans, after months of delay, have finally chosen to join us to extend the advanced premium tax credits.

That is why it is time for the Speaker to bring the House Democrats' bipartisan discharge petition to the floor immediately.

Every Member must make a choice. Stand with the working men and women of this country and small businesses or Donald Trump.

Vote ''no'' on this sham of a bill. Vote ''yes'' on the Jeffries discharge petition.

Mr. SMITH of Missouri. Mr. Speaker, I have no additional speakers. I am prepared to close, and I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, may I inquire as to the time remaining.

The SPEAKER pro tempore (Mr. PATRONIS). The gentleman from Massachusetts has 30 seconds remaining.

Mr. NEAL. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, my constituent company, Merriam-Webster, declared this week that the word of the year is ''slop,'' and it is appropriate today.

This bill won't lower costs. Without the ACA tax credits, costs are going to skyrocket for the American people. That is a bombshell report. They are undermining protections and forcing people into junk plans.

The only path forward is Leader JEFFRIES' discharge petition. It is a 3-year extension, clear and clean, bipartisan.

Mr. Speaker, I urge Speaker JOHNSON to bring this legislation up, and I yield back the balance of my time.

Mr. SMITH of Missouri. Mr. Speaker, we have heard a lot of comments from the Democrats on this side of the floor.

Back where I come from, the comments that I have heard, we call it hogwash, because it has not been true and it has not been factual. This bill before you will lower healthcare costs for all Americans, not just the 7 percent that they are fighting for. It lowers costs for all 347 million.

The SPEAKER pro tempore. The time of the gentleman has expired.

□ 1210

The SPEAKER pro tempore. The gentleman from Michigan (Mr. WALBERG) and the gentleman from Virginia (Mr. SCOTT) each will control 10 minutes.

The Chair recognizes the gentleman from Michigan.

Mr. WALBERG. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 6703.

Because of the unaffordable care act, healthcare costs are out-of-control, and small businesses and the families that they employ are paying the price. The unaffordable care act drove premiums up and added red tape forcing many small employers to drop coverage or stop offering it altogether.

Now my Democrat colleagues want to extend enhanced benefits that they couldn't get their own party to support for more than 3 years when they passed them.

They made this problem, and now they want us to fix it by doing the same thing that has extended this problem. They want our family, friends, and neighbors to suffer further pain as opposed to joining us and fixing the problem as opposed to extending it.

My bill, the Association Health Plans Act, allows small businesses and self-employed Americans to band together, like large companies, to lower costs and deliver high-quality coverage. The CBO report today estimates that this could cover more than 200,000 previously uninsured Americans and attract 700,000 people annually to association health plans.

Complementing this, the Self-Insurance Protection Act, authored by Representative BOB ONDER, shields small businesses from regulatory overreach while expanding affordable healthcare options.

Together, these measures, included in the Lower Health Care Premiums for All Americans Act, cut red tape, protect choice, and lower costs.

I plead with my Democrat colleagues to join us in bringing about a remedy to our healthcare system which is broken because of the unaffordable care act.

They broke it, but please join us to fix it.

Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in opposition to the so-called Lower Health Care Premiums for All Americans Act.

This package includes two partisan proposals marked up in the Education and Workforce Committee. First, it recklessly expands association health plans which would allow small employer groups and individuals to join associations to offer health insurance that are subject to fewer regulations than traditional plans in the individual and small group markets.

AHPs would make it easier for associations to cherry-pick small employers with younger, mostly male workforces who are healthier and can be charged lower rates. Smaller employers whose workers are older and sicker would remain in the traditional market. Simple arithmetic dictates that if you pull healthy groups out, then all of those left behind will be paying more.

Furthermore, these plans, if history is any guide, will show that they are more vulnerable to fraud and insolvency than those in the marketplace.

The second proposal is the Self-Insurance Protection Plan which would prohibit the Department of Labor and States from ever regulating stop-loss

insurance, inviting nefarious practices that could hurt consumers and employers by creating loopholes for plans that will escape any regulatory oversight.

Further, Mr. Speaker, this plan does nothing to extend the ACA enhanced tax credits which are set to expire. Millions of people will see their premiums skyrocket, and millions more won't be able to afford any insurance at all. If we bring up the bipartisan bill, then we could avoid that result.

Mr. Speaker, I reserve the balance of my time.

Mr. WALBERG. Mr. Speaker, I yield 2 minutes to the gentleman from Utah (Mr. OWENS), who is the chairman of the Subcommittee on Higher Education.

Mr. OWENS. Mr. Speaker, today I rise to speak in strong support of the Lower Health Care Premiums for All Americans Act.

This legislation will make it easier for small businesses to offer quality, affordable healthcare coverage to their employees by allowing them to band together to have access to the same regulatory and economic benefits as large group plans.

Right now, small businesses are on an unequal playing field with larger companies and unions. Because they have fewer employees, small business have limited bargaining power when it comes to negotiating lower insurance costs for their workers. Since 2010, the share of small businesses with fewer than 50 employees offering health coverage has dropped from 39 to 30 percent.

Small businesses have ranked the cost of health insurance as their number one problem for 32 straight years. For nearly four decades, it has remained the top concern. In fact, 98 percent of small businesses report that healthcare costs will become unsustainable in the next 5 to 10 years, threatening their ability to survive and remain competitive.

This is not because small businesses do not want to offer healthcare benefits. Small business owners work very hard to provide for their employees. The problem is that healthcare in this country has become simply unaffordable for far too many businesses and working families.

Employers are looking for innovative solutions to lower costs and increase coverage for their employees. When asked, 79 percent of employers reported they were interested in joining an association health plan. We know these plans work. Under the first Trump administration's association health plan rule, healthcare costs for those enrolled in an AHP decreased for some industries by more than 50 percent.

The Lower Health Care Premiums for All Americans Act would level the playing field for small businesses and empower their employees to access quality healthcare at a lower cost. It also represents an essential step toward purchasing health insurance across State lines.

As we continue our efforts to lower costs for small business owners and workers, this is just one step we can take to make sure that more Americans can access high-quality, affordable healthcare.

Mr. Speaker, I urge my colleagues to vote ''yes'' on H.R. 6703.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. DESAULNIER), who is the ranking member of the Health Employment Subcommittee.

Mr. DESAULNIER. Mr. Speaker, I thank the ranking member for yielding.

Mr. Speaker, I rise as a former small business owner having over three decades owning and managing restaurants in strong opposition to this sad healthcare plan.

After kicking 10 million Americans off Medicaid in the big, ugly bill, Republicans are following up with this proposal that the Congressional Budget Office says will take healthcare away from an additional 100,000 Americans a year.

We need to make healthcare more affordable for all Americans. Despite spending 18½ percent of our GDP in the United States on healthcare, we have the worst outcomes: the highest mortality rate, life expectancy, and acuity.

We need to make it more affordable. I agree with the ranking member and the chair that we should work together on the inefficiencies in the system. However, this is not it.

After spending 15 years on their healthcare plan, Republicans have just repackaged some of their old ideas, and they are hoping the American people won't notice that it is not going to help. Instead, we should extend the tax credits for 3 years and come together.

Mr. WALBERG. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. KILEY), who is the chairman of the Subcommittee on Early Childhood, Elementary, and Secondary Education.

□ 1220

Mr. KILEY of California. Mr. Speaker, I will be voting for this measure today because the policy is good, but let's be realistic. It is extremely modest, and it has no chance of becoming law because it was hastily thrown together without, apparently, any bipartisan input, when bipartisan support is necessary to pass any measure like this.

However, worst of all, the bill does not address the immediate urgent problem in front of us, which is that 22 million people are about to pay a lot more for health insurance. These are independent contractors, freelancers, gig workers, and Uber drivers. It is small business owners and their employees, and retirees who are not yet eligible for Medicare who are going to pay thousands of dollars more in many cases. Some people won't be able to afford health insurance at all.

What are we supposed to tell these folks? ''Oh, don't worry, it is Obama's fault.'' Or, ''Oh, no, don't worry, we did a show vote on this Lower Health Care Premiums for All Americans Act.'' Is that going to be any consolation?

Now, I have been extremely critical of the House Speaker for refusing to put any measure to extend these tax credits on the floor, and I think that criticism right now is more well deserved than ever.

We have in the past seen measures come to the floor that divided the Republican Conference but that were able to pass with bipartisan support on continuing resolutions or on foreign aid bills. There is no reason that cannot be done here, and let the House work its will. That, after all, is the best expression of the will of the people.

What about the minority leader, HAKEEM JEFFRIES? He has had every opportunity to endorse a compromise measure that has a temporary extension with reforms. There are three bills that have numerous bipartisan coauthors, but instead of supporting any of those, he has directed his Members to only support an uncompromising measure that has zero bipartisan cosponsors. That has already been rejected by the Senate and so has no chance of becoming law.

This whole issue encapsulates what is wrong with this institution, where party leaders focus most of their time and energy on trying to blame problems on the other side rather than trying to solve those problems, but it is not too late for action now. I am calling on the Speaker or the minority leader or both to get a bill to the floor. That is what this institution needs. It is what America needs.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentlewoman from North Carolina (Ms. ADAMS), the ranking member of the Higher Education and Workforce Development Subcommittee.

Ms. ADAMS. Mr. Speaker, I rise to speak for the 186 Americans who have lost their lives today, not because of disease or illness, but because they did not have access to the health insurance they needed to get treatment.

Every year, 68,000 Americans die because they do not have health insurance, and Republicans have chosen to turn their backs on these Americans and make this crisis worse.

Not only does their bill fail to extend the ACA tax credits, something that helps 88,000 folks in my district afford health insurance, it abandons financial assistance for middle-class families when they are already struggling to make ends meet. It strips away protections for patients, opening them up to discrimination and predatory practices. It restricts access to abortion care which, by the way, is healthcare, putting the government, not a woman and her doctor, in charge of her body.

People are dying, Mr. Speaker, and it is time Republicans take this crisis seriously. Republicans need to wake up. Have some compassion. Our constituents cannot wait. Let's vote ''no'' on

this awful Republican bill, Mr. Speaker.

Mr. WALBERG. Mr. Speaker, I yield 2 minutes to the gentleman from Missouri (Mr. ONDER).

Mr. ONDER. Mr. Speaker, I rise in strong support of the Lower Health Care Premiums for All Americans Act, which includes legislation which I introduced earlier this year, the Self-Insurance Protection Act. This bill ensures that employers who choose to self-insure retain access to a critical financial tool: stop-loss insurance.

Many employers choose to self-insure so they can tailor coverage to the specific needs of their workforce. This flexibility lowers healthcare costs and increases take-home pay for employees. However, self-insurance carries a greater financial risk, which is why employers rely on stop-loss insurance to protect against catastrophic claims.

In recent years, some States have tried to regulate self-insurance out of existence. States like New York have barred small employers from purchasing stop-loss insurance. For years, Democrats, in their pursuit of single-payer healthcare, have tried to regulate it as traditional health insurance. The Self-Insurance Protection Act makes it clear that stop-loss insurance is a financial safeguard, not health insurance.

The Lower Health Care Premiums for All Americans Act will expand access to other options that increase competition and lower costs, like association health plans. The first Trump administration expanded access to associated health plans and lowered costs by 26 percent.

Through AHPs, employers can pool together to set up their own insurance plan and negotiate better healthcare coverage. This approach could eventually allow Costco or Sam's Club to offer their own revolutionary low-cost health insurance.

As a physician, I have seen firsthand that increasing competition and choice lowers costs, and the Lower Health Care Premiums for All Americans Act will deliver lower costs for the 78 percent of Americans who receive insurance through their employer. In addition, it will lower ObamaCare premiums by 11 percent.

Mr. Speaker, I strongly support this bill and urge its passage.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 45 seconds to the gentleman from Ohio (Mr. LANDSMAN).

Mr. LANDSMAN. Mr. Speaker, of the 22 million Americans who rely on the Affordable Care Act subsidies, 32,000 live in my district. They are about to experience healthcare costs that are skyrocketing. They want one thing, that is it, Mr. Speaker. They want one thing. They want us to extend the Affordable Care Act subsidies. Eighty percent of Americans have said this is what they want. These are farmers, small businesses, and families. If they were in this Chamber today, they would point to the well and say: There are 218 signatures on this discharge petition. Just put it on the floor, vote for it, and give us the subsidies that help us pay for our healthcare.

Mr. WALBERG. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I rise today in strong support of the Lower Health Care Premiums for All Americans Act, which is the right prescription to lower healthcare costs and provide American citizens with more affordable coverage.

Nearly 15 years ago, the Democrats unaffordable care act broke our healthcare system. They broke our healthcare system. Since its inception, ObamaCare premiums have skyrocketed by over 220 percent. A family of four now pays $10,000 more for coverage today than they did before ObamaCare, and their deductibles have doubled, in part to offset waste, fraud, and abuse that runs rampant throughout the program.

Rather than fix the problems of the unaffordable care act, Democrats in Congress want to continue to send billions of taxpayer money directly to giant insurance companies and leave families with thousands of dollars in healthcare costs that they cannot afford.

The unaffordable care act is broken, and throwing more hard-earned taxpayer money after bad policy is not going to fix it. That is why we must give power to the patient, not to the big insurance companies.

While Republicans are working to make life more affordable, Democrats' prescription is to raise taxes. Mr. Speaker, I encourage my colleagues to support the Lower Health Care Premiums for All Americans Act.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. TAKANO), the ranking member of the Veterans' Affairs Committee.

Mr. TAKANO. Mr. Speaker, I rise in strong opposition to this bill.

My Republican colleagues have tried and failed to repeal or weaken the Affordable Care Act more than 70 times over the past 15 years.

The bill before us does nothing to address the expiring tax credits, and contrary to what my colleague Mr. KILEY has said, the bill that would extend the tax credits is bipartisan. It would pass this House.

In the richest country in the world, the country that is the global leader in medical innovation, Americans will die from treatable conditions.

Republicans claim that their bill will give consumers more choices. No choice, this is not about choice. People will have the choice to be refused health insurance for preexisting conditions by unregulated junk health insurance plans and be denied reproductive healthcare.

Instead of making the ACA tax credits permanent, Republicans have once again proposed a piecemeal, non-solution that makes health insurance more expensive and strips Americans of their basic healthcare rights.

Mr. Speaker, vote against this bill. Bring the bipartisan solution to the floor.

Mr. WALBERG. Mr. Speaker, may I inquire how much time I have remaining.

The SPEAKER pro tempore. The gentleman from Michigan has 30 seconds remaining.

Mr. WALBERG. Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 45 seconds to the gentlewoman from Virginia (Ms. MCCLELLAN).

Ms. MCCLELLAN. Mr. Speaker, I rise in opposition to this bill. In just 15 days, health insurance premiums will skyrocket for more than 20 million Americans.

At a time when people are already struggling with higher costs for groceries, rent, childcare, and utilities, this bill does nothing to stop the immediate harm heading their way on January 1.

Here is what that looks like for Virginians in Virginia: A 60-year-old couple earning $85,600 a year will see their premiums rise by $15,446, and a family of four earning $66,000 a year will see their premiums jump $2,651.

Mr. Speaker, these are not abstract numbers. They are small business owners, employees, farmers, gig workers, self-employed, and more who will be forced to make impossible choices.

We still have time. We can pass a bill now to extend the tax credits. We should do so.

□ 1230

Mr. WALBERG. Mr. Speaker, I am prepared to close, and I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, may I inquire as to the time remaining.

The SPEAKER pro tempore (Mr. ROGERS of Alabama). The gentleman from Virginia has 4 minutes remaining.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 45 seconds to the gentlewoman from Arizona (Mrs. GRIJALVA).

Mrs. GRIJALVA. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, first and foremost, I will state that nobody should ever be denied basic healthcare, period. No one is better off when people are forced to receive healthcare in emergency rooms or receive a later stage diagnosis because of lack of preventive care and seeing a doctor on a regular basis.

Over 22 million people, including 400,000 Arizonans, with marketplace coverage are seeing their premiums skyrocket.

I cannot state this any clearer: People cannot afford to pay more for their healthcare and shouldn't be forced to. Allowing premiums to skyrocket, enacting a backdoor abortion ban, and allowing plans to not cover things like maternity care and preexisting conditions is not a solution. It is abandonment.

Mr. Speaker, I urge a ''no'' vote on this bill.

Mr. WALBERG. Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. CARTER).

Mr. CARTER of Louisiana. Mr. Speaker, for months, Democrats have urged Republicans to come to the table to work together on a clean extension of the Affordable Care Act tax credits. Now, we are just days away from the deadline, and Republicans are scrambling to push through an unserious proposal at the eleventh hour. People aren't stupid. They can see this.

Their so-called Lower Health Care Premiums for All Americans Act would have the exact opposite effect than what it claims to do.

Most importantly, it does nothing to extend the ACA tax credits. The tax credits have been a lifeline for countless hardworking families, small business owners, and seniors in Louisiana and across our country, helping them afford coverage in a time when the cost of living continues to climb. This is something that we, as Members of Congress, should do. Without these extensions, their premiums will skyrocket.

Healthcare is not a luxury. It is a fundamental human right.

Mr. Speaker, I stand with Leader JEFFRIES and House Democrats as we continue our fight for affordable, quality healthcare in this country.

Mr. WALBERG. Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. UNDERWOOD).

Ms. UNDERWOOD. Mr. Speaker, I rise today because, in just 2 weeks, the Affordable Care Act tax credits that help millions of Americans afford their premiums will expire, and this Republican healthcare bill does absolutely nothing to keep costs from surging.

In fact, every House Democrat has signed a discharge petition for my bill to extend these tax credits for 3 years, and now four Republicans have signed on, as well.

For this reason, at the appropriate time, I will offer a motion to recommit this bill back to committee. If the House rules permitted, I would have offered the motion with an important amendment to this bill.

My amendment would extend the enhanced premium tax credits for 3 years to do what this Republican bill fails to do and help American families afford their healthcare.

Mr. Speaker, I ask unanimous consent to include in the RECORD the text of this amendment immediately prior to the motion to recommit.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Illinois?

There was no objection.

Ms. UNDERWOOD. Mr. Speaker, I hope my colleagues will join me in voting for the motion to recommit.

Mr. WALBERG. Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, may I inquire as to the time remaining.

The SPEAKER pro tempore. The gentleman from Virginia has 1¼ minutes remaining.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. RUIZ).

Mr. RUIZ. Mr. Speaker, Republicans just passed their big, ugly law that rips Medicaid by nearly a trillion dollars, adds 15 million people uninsured, and raises costs for everybody. Now, to add insult to injury, they refuse to extend the Affordable Care Act.

This bill that they want to replace it with is a bamboozle. It is a hoodwink. It is a scam for the American people. It promotes junk plans that rip off the American people. It does not cover essential health benefits. It allows them to discriminate against people with preexisting conditions, increases out-of-pocket costs, and will lead to millions more uninsured.

Mr. WALBERG. Mr. Speaker, I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 30 seconds to the gentlewoman from Oregon (Ms. DEXTER).

Ms. DEXTER. Mr. Speaker, I rise today in strong opposition to the GOP higher healthcare costs for worse coverage act.

I did not spend 20 years as an ICU doctor saving lives to come to Congress and sit back while Republicans strip healthcare coverage from millions. No. I came to Congress to fight for affordable, accessible healthcare for all.

This bill does nothing to accomplish that goal. Worse than that, it pushes people toward less coverage at a higher cost and opens a backdoor abortion ban that marches us a step closer to a national one.

Mr. WALBERG. Mr. Speaker, I am prepared to close, and I reserve the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, this bill does nothing to reduce costs for all Americans. By weakening protections, undermining State oversight, and siphoning healthy individuals out of the ACA, this bill will actually increase premiums and reduce oversight and protection for families.

We need to extend the 3-year extension for the enhanced tax credits. I oppose the bill and urge my colleagues to do the same.

Mr. Speaker, I yield back the balance of my time.

Mr. WALBERG. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, most Americans rely on employer-provided healthcare, but government-driven costs are making that coverage more expensive every year. Families are paying more, and small businesses are struggling to keep up with the mandates and the red tape.

Americans deserve affordable, high-quality coverage that puts decisions back where they belong with workers, families, and employers, not the Federal Government.

Bottom line, the Lower Health Care Premiums for All Americans Act empowers workers and job creators and makes healthcare more affordable for everyday Americans. By the way, perchance you want to keep the unaffordable care act for yourself, you still can.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 953, the previous question is ordered on the bill.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Ms. UNDERWOOD. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Ms. Underwood of Illinois moves to recommit the bill H.R. 6703 to the Committee on Energy and Commerce.

The material previously referred to by Ms. UNDERWOOD is as follows:

Ms. Underwood moves to recommit the bill H.R. 6703 to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. EXTENSION OF ENHANCED HEALTH INSURANCE PREMIUM TAX CREDIT.

(a) IN GENERAL.—Section 36B(c)(1)(E) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''January 1, 2026'' and inserting ''January 1, 2029'', and

(2) by striking ''2025'' in the heading thereof and inserting ''2028''.

(b) APPLICABLE PERCENTAGES.—Section 36B(b)(3)(A)(iii) of such Code is amended—

(1) by striking ''January 1, 2026'' and inserting ''January 1, 2029'', and

(2) by striking ''2025'' in the heading thereof and inserting ''2028''.

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

The SPEAKER pro tempore. Pursuant to clause 2(b) of rule XIX, the previous question is ordered on the motion to recommit.

The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Ms. UNDERWOOD. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

□ 1240

DIRECTING THE PRESIDENT, PURSUANT TO SECTION 5(c) OF THE WAR POWERS RESOLUTION, TO REMOVE UNITED STATES ARMED FORCES FROM HOSTILITIES WITH PRESIDENTIALLY DESIGNATED TERRORIST ORGANIZATIONS IN THE WESTERN HEMISPHERE

Mr. MAST. Mr. Speaker, pursuant to the order of the House of December 16, 2025, I call up the concurrent resolution (H. Con. Res. 61) directing the President, pursuant to section 5(c) of the War Powers Resolution, to remove United States Armed Forces from hostilities with presidentially designated terrorist organizations in the Western Hemisphere, and ask for its immediate consideration in the House.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. Pursuant to the order of the House of December 16, 2025, the concurrent resolution is considered as read.

The text of the concurrent resolution is as follows:

H. CON. RES. 61

Resolved by the House of Representatives (the Senate concurring), That, pursuant to section 5(c) of the War Powers Resolution (50 U.S.C. 1544(c)), Congress directs the President to remove United States Armed Forces from hostilities with any presidentially designated terrorist organization in the Western Hemisphere, unless authorized by a declaration of war or a specific congressional authorization for use of military force against such presidentially designated terrorist organization.

The SPEAKER pro tempore. The concurrent resolution shall be debatable for 1 hour, equally divided and controlled by the chair and ranking minority member of the Committee on Foreign Affairs or their respective designees.

The gentleman from Florida (Mr. MAST) and the gentleman from New York (Mr. MEEKS) each will control 30 minutes.

GENERAL LEAVE

Mr. MAST. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. MAST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, right now we have cartels operating in our backyard. They are kidnapping Americans, extorting families, trafficking women and children, and flooding our towns with fentanyl to maximize death and addiction on American soil.

Someone tell me that I am wrong. I don't hear anything. Just look at the images next to me. It is not photoshopped. None of this is new. It is just new that it is being defeated by President Trump and brought to an end by President Trump. This violence comes from the Sinaloa and Jalisco cartels. It comes from Tren de Aragua, MS–13, and Cartel of the Suns, headed by Nicolas Maduro, just to name a few.

The President has every bit of Article II authority to defend the United States of America from these imminent threats. These cartels that are doing this are an imminent threat. These cartels have tens of thousands of members who wake up every day and see it as their sole mission to flood the United States with lethal drugs. My Democrat colleagues want to ignore that.

Sinaloa and Jalisco alone have 45,000 members combined. The Gulf Cartel has 50,000 members. MS–13 has another 30,000. They are coming across the Gulf constantly. Mr. Speaker, 365 days a year, 7 days a week, they are coming to the United States of America with their violence. That is the definition of ''imminent.''

These drug cartels are highly organized and militarized. They are terrorist networks that have convinced my colleagues they are nothing more than small street gangs.

They control territory, run armed convoys, use drones for surveillance, and communicate through encrypted networks like the military. They terrorize entire countries with extreme violence, and they terrorize the United States of America and our people. They spread carnage wherever they go, not just across the border but on our side of the border, as well, right here in the United States of America.

Look at this morbid scene we will put up here. These two men are about to be decapitated literally out in the open by the Gulf Cartel. The tactics of these cartels are the same as those used by al-Qaida and ISIS. These are terrorist networks. Some are given safe haven by foreign governments. Others, like Tren de Aragua, take orders from Nicolas Maduro. Americans have paid the price for it.

Laken Riley, a 22-year-old nursing student, was murdered in Georgia by a confirmed member of Tren de Aragua. Claretha Daniels and Justin Lawless were executed outside of their Bronx apartment by six Tren de Aragua terrorists. These were neighbors of my ranking member.

Mr. Speaker, a 74-year-old American rancher was killed in Brownsville, Texas, when his truck hit an IED planted by the cartel. That is exactly the same kind of thing that took off my legs.

Democrats don't want the President to be able to defend America from these terrorists. Even more tragic is the fact that nearly 80,000 Americans overdosed last year on fentanyl, cocaine, and other drugs trafficked by cartels. Democrats don't want to protect us from that either.

In fact, yesterday, after we had a classified briefing, the gentleman on my left, the ranking member, went directly to the press to claim that these strikes were not protecting America. He literally said that these strikes were not stopping drugs. Everything that he said is very easy for me to prove wrong.

Every drug boat sunk is literally drugs not coming to the United States of America. Every narcoterrorist killed is an American life, like Laken Riley or Claretha Daniels, saved. The threat is pressing, and it is frequent.

In November, the Coast Guard announced it seized 510,000 pounds of cocaine in the eastern Pacific and the Caribbean since the start of 2025. This is enough cocaine to harm nearly 170 million Americans. Congressional authorization is not required to carry out precise, limited strikes.

My colleagues did not object when prior Presidents conducted military operations in Yemen and Libya and Syria, operations which were also limited and successful.

This resolution is also reckless and poorly written. It prevents the President from acting against any foreign terrorist organization in the Western Hemisphere. Under this resolution, the President could strike al-Qaida or ISIS in the Middle East. If those same terrorists came across into the Western Hemisphere, they could be untouchable and free to kill as many Americans as they want.

Democrats are not putting forward an authorized use of military force, telling the President how to combat any of these issues. Democrats are putting forward a resolution to say the President cannot do anything about MS–13 or Tren de Aragua and every other cartel. That is giving aid and comfort to narcoterrorists. That is ignoring an imminent threat.

The cartels are relentless and ruthless. They have military capabilities and use them every day against the American homeland. When a threat poses immediate danger to Americans, the Constitution gives the President the authority to act.

Mr. Speaker, I reserve the balance of my time.

Mr. MEEKS. Mr. Speaker, I yield myself such time as I may consume for the purpose of speaking in favor of H. Con. Res. 61.

Mr. Speaker, I will get to the chairman's remarks later about his incorrect statements. What I want to point out is, since September 2, the administration has carried out 25 known strikes, killing 95 people. Among these was a so-called double-tap strike where U.S. Forces killed two survivors clinging to the wreckage of a destroyed vessel in open sea.

The administration now refuses to release the video of this strike, denying the American people the ability to see for themselves what is being done in their names. In fact, they are denying Members of this House, including me and I believe the chairman himself, from seeing that video. Many believe this strike may constitute a war crime.