

**AMENDMENT TO H.R. 6703, AS REPORTED  
OFFERED BY MR. LALOTA OF NEW YORK**

At the appropriate place, insert the following:

1   **SEC. \_\_\_\_\_. TEMPORARY DEDUCTION FOR HEALTH INSUR-**  
2                                   **ANCE EXCHANGE PREMIUMS.**

3           (a) IN GENERAL.—Part VII of subchapter B of chap-  
4   ter 1 of the Internal Revenue Code of 1986 is amended  
5   by inserting after section 213 the following new section:

6   **“SEC. 213A. HEALTH INSURANCE EXCHANGE PREMIUMS.**

7           “(a) IN GENERAL.—In the case of an eligible indi-  
8   vidual, there shall be allowed as a deduction for the tax-  
9   able year amounts paid by the taxpayer for a qualified  
10   health plan (as defined in section 36B(c)(3)(A)) for the  
11   taxpayer, the taxpayer’s spouse, or any dependent (as de-  
12   fined in section 152).

13          “(b) ELIGIBLE INDIVIDUAL.—For purposes of this  
14   section, the term ‘eligible individual’ means an indi-  
15   vidual—

16               “(1) who paid amounts described in subsection  
17           (a) for at least 6 coverage months (as defined in sec-  
18           tion 36B(c)(2)) during the taxable year, and

19               “(2) meets such additional eligibility require-  
20           ments as the Secretary may prescribe by regulations.

1 “(c) LIMITATION.—

2 “(1) IN GENERAL.—The Secretary shall estab-  
3 lish such limitations on the deduction allowed under  
4 this section as are necessary to ensure that the ag-  
5 gregate reduction in Federal revenues attributable to  
6 this section for each of taxable years 2025 and 2026  
7 is not less than \$25,000,000,000 and not more than  
8 \$30,000,000,000.

9 “(2) METHOD OF ESTIMATION.—To the max-  
10 imum extent practicable, the estimates of the Sec-  
11 retary under paragraph (1) shall be made in the  
12 same manner as such estimates are made by the  
13 Congressional Budget Office and the Joint Com-  
14 mittee on Taxation with respect to proposed legisla-  
15 tion.

16 “(d) COORDINATION WITH OTHER PROVISIONS.—

17 “(1) PREMIUM TAX CREDIT.—No deduction  
18 shall be allowed under this section for the aggregate  
19 premiums taken into account under section  
20 36B(b)(2)(A).

21 “(2) MEDICAL DEDUCTION.—Any amount paid  
22 by a taxpayer for insurance to which subsection (a)  
23 applies shall not be taken into account in deter-  
24 mining the deduction under section 213(a).

1       “(e) REGULATIONS AND GUIDANCE.—The Secretary  
2 may prescribe such regulations and guidance as are nec-  
3 essary to administer this section, including regulations—

4               “(1) establishing a methodology to meet the  
5 limitation requirements under subsection (c)(1),

6               “(2) ensuring the deduction is targeted to  
7 households for whom health insurance affordability  
8 is a significant burden, including by incorporating  
9 household size and Federal poverty guidelines into  
10 the amount allowed as a deduction and phasing out  
11 the amount of the deduction as appropriate, and

12              “(3) promoting affordability and equitable ac-  
13 cess to health insurance.

14       “(f) TERMINATION.—No deduction shall be allowed  
15 under this section for amounts paid with respect to a plan  
16 year which begins after December 31, 2026.”.

17       (b) DEDUCTION ALLOWED WHETHER OR NOT TAX-  
18 PAYER ITEMIZES.—Section 62(a) of such Code is amended  
19 by inserting after paragraph (21) the following new para-  
20 graph:

21              “(22) HEALTH INSURANCE EXCHANGE PRE-  
22 MIUMS.—The deduction allowed by section 213A.”.

23       (c) CLERICAL AMENDMENT.—The table of sections  
24 for part VII of subchapter B of chapter 1 of such Code

1 is amended by inserting after the item relating to section  
2 213 the following new item:

“Sec. 213A. Health insurance exchange premiums.”.

3 (d) **EFFECTIVE DATE.**—The amendments made by  
4 this section shall apply to taxable years beginning after  
5 December 31, 2024.

6 **SEC. \_\_\_\_.** **GUARDRAILS TO PREVENT FRAUD IN EX-**  
7 **CHANGES.**

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

10 (1) **PENALTIES FOR AGENTS AND BROKERS.**—

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

14 (A) in subparagraph (A)—

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

17 (ii) in clause (i)—

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

1 failure is attributable to negligence or  
2 disregard of any rules or regulations  
3 of the Secretary, such person”; and

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

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

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

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

1           ject of an application for which such incor-  
2           rect information is provided.”; and

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

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

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

10                   “(i) IN GENERAL.—Any person”; and

11                   (iii) by adding at the end the fol-  
12           lowing:

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

15                   “(I) IN GENERAL.—Any agent or  
16           broker who knowingly provides false  
17           or fraudulent information under sub-  
18           section (b) or section 1311(c)(8), or  
19           other false or fraudulent information  
20           as part of an application for enroll-  
21           ment in a qualified health plan offered  
22           through an Exchange, as specified by  
23           the Secretary, shall be subject, in ad-  
24           dition to any other penalties that may  
25           be prescribed by law, including sub-

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

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

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

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

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

3 (2) CONSUMER PROTECTIONS.—

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4                     “(i) agents or brokers—”; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20                   “(I) are intended—

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



1 such plan or plans offered  
2 through an Exchange;

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

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

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

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

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

24 “(II) the expiration of such con-  
25 tract or business arrangement that is

1 not replaced by a substantially similar  
2 agreement.

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

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

17 “(2) AUDITS.—

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

1 and other applicable Federal and State law (in-  
2 cluding regulations) that shall include—

3 “(i) periodic audits of agents and bro-  
4 kers based on—

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

10 “(II) an incident or enrollment  
11 pattern that suggests fraud; and

12 “(III) other factors determined  
13 by the Secretary; and

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

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

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

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

6 “(9) REMOVAL OF DECEASED INDIVIDUALS  
7 FROM EXCHANGE PLANS.—

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

17 “(B) PROCESS.—The Secretary shall—

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

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

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

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

17 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIV-  
18 IDUALS OF VALUE OF PREMIUM TAX CREDITS AND DE-  
19 Ductions.—Section 1412(c)(2) of the Patient Protection  
20 and Affordable Care Act (42 U.S.C. 18082(c)(2)) is  
21 amended by adding at the end the following new subpara-  
22 graph:

23 “(C) EXCHANGE RESPONSIBILITIES.—Be-  
24 ginning January 1, 2027, if an Exchange is no-  
25 tified under paragraph (1) of an advance deter-

1 mination under section 1411 with respect to the  
2 eligibility of an individual for a premium tax  
3 credit under section 36B of the Internal Rev-  
4 enue Code of 1986 or a tax deduction under  
5 section 213A of such Code, the Exchange shall,  
6 prior to enrolling such individual in a qualified  
7 health plan, clearly notify such individual of the  
8 amount of such tax credit.”.

9 **SEC. \_\_\_\_\_. EXTENDING ANNUAL OPEN ENROLLMENT PE-**  
10 **RIOD FOR EXCHANGES FOR PLAN YEAR 2026.**

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

19 (b) NOTIFICATION OF OPEN ENROLLMENT EXTEN-  
20 SION.—The Secretary of Health and Human Services  
21 shall perform such outreach activities as are necessary to  
22 inform qualified individuals (as defined in section  
23 1312(f)(1) of the Patient Protection and Affordable Care  
24 Act (42 U.S.C. 18032(f)(1))) of the extended open enroll-  
25 ment period provided for under subsection (a).

1 **SEC. \_\_\_\_\_. MODERNIZING AND ENSURING PBM ACCOUNT-**  
2 **ABILITY.**

3 (a) IN GENERAL.—

4 (1) PRESCRIPTION DRUG PLANS.—Section  
5 1860D–12 of the Social Security Act (42 U.S.C.  
6 1395w–112) is amended by adding at the end the  
7 following new subsection:

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

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

21 “(A) NO INCOME OTHER THAN BONA FIDE  
22 SERVICE FEES.—

23 “(i) IN GENERAL.—The pharmacy  
24 benefit manager and any affiliate of such  
25 pharmacy benefit manager shall not derive  
26 any remuneration with respect to any serv-

1           ices provided on behalf of any entity or in-  
2           dividual, in connection with the utilization  
3           of covered part D drugs, from any such en-  
4           tity or individual other than bona fide serv-  
5           ice fees, subject to clauses (ii) and (iii).

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



1                   “(iii) CLARIFICATION ON REBATES  
2                   AND DISCOUNTS USED TO LOWER COSTS  
3                   FOR COVERED PART D DRUGS.—Rebates,  
4                   discounts, and other price concessions re-  
5                   ceived by a pharmacy benefit manager or  
6                   an affiliate of a pharmacy benefit manager  
7                   from manufacturers, even if such price  
8                   concessions are calculated as a percentage  
9                   of a drug’s price, shall not be considered a  
10                  violation of the requirements of clause (i)  
11                  if they are fully passed through to a PDP  
12                  sponsor and are compliant with all regu-  
13                  latory and subregulatory requirements re-  
14                  lated to direct and indirect remuneration  
15                  for manufacturer rebates under this part,  
16                  including in cases where a PDP sponsor is  
17                  acting as a pharmacy benefit manager on  
18                  behalf of a prescription drug plan offered  
19                  by such PDP sponsor.

20                  “(iv) EVALUATION OF REMUNERATION  
21                  ARRANGEMENTS.—Components of subsets  
22                  of remuneration arrangements (such as  
23                  fees or other forms of compensation paid  
24                  to or retained by the pharmacy benefit  
25                  manager or affiliate of such pharmacy ben-

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

22               “(v) DISGORGEMENT.—The pharmacy  
23          benefit manager shall disgorge any remu-  
24          neration paid to such pharmacy benefit  
25          manager or an affiliate of such pharmacy

1 benefit manager in violation of this sub-  
2 paragraph to the PDP sponsor.

3 “(vi) ADDITIONAL REQUIREMENTS.—

4 The pharmacy benefit manager shall—

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

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

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

22 “(i) define, interpret, and apply, in a  
23 fully transparent and consistent manner  
24 for purposes of calculating or otherwise  
25 evaluating pharmacy benefit manager per-

1 formance against pricing guarantees or  
2 similar cost performance measurements re-  
3 lated to rebates, discounts, price conces-  
4 sions, or net costs, terms such as—

5 “(I) ‘generic drug’, in a manner  
6 consistent with the definition of the  
7 term under section 423.4 of title 42,  
8 Code of Federal Regulations, or a suc-  
9 cessor regulation;

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

15 “(III) ‘specialty drug’;

16 “(IV) ‘rebate’; and

17 “(V) ‘discount’;

18 “(ii) identify any drugs, claims, or  
19 price concessions excluded from any pric-  
20 ing guarantee or other cost performance  
21 measure in a clear and consistent manner;  
22 and

23 “(iii) where a pricing guarantee or  
24 other cost performance measure is based  
25 on a pricing benchmark other than the

1           wholesale acquisition cost (as defined in  
2           section 1847A(c)(6)(B)) of a drug, cal-  
3           culate and provide a wholesale acquisition  
4           cost-based equivalent to the pricing guar-  
5           antee or other cost performance measure.

6           “(C) PROVISION OF INFORMATION.—

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

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

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

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

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

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

24 “(ee) the average wholesale  
25 price for the drug, listed as price

1 per day's supply, price per dos-  
2 age unit, and price per typical  
3 course of treatment (as applica-  
4 ble);

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

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

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

1 “(ii) the average pharmacy  
2 reimbursement amount paid by  
3 the plan for the drug in the ag-  
4 gregate and disaggregated by dis-  
5 pensing channel identified in item  
6 (cc);

7 “(jj) the average National  
8 Average Drug Acquisition Cost  
9 (NADAC); and

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

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

23 “(aa) The percentage of  
24 total prescriptions that were dis-  
25 pensed by pharmacies that are an



1 affiliate of the pharmacy benefit  
2 manager for each drug.

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

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

1                   “(dd) The lowest total com-  
2                   bined cost paid by the plan and  
3                   plan enrollees, per dosage unit,  
4                   per course of treatment, per 30-  
5                   day supply, and per 90-day sup-  
6                   ply, for each drug that is avail-  
7                   able from any pharmacy included  
8                   in the pharmacy network of such  
9                   plan.

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

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

1 macy benefit manager or an affil-  
2 iate of the pharmacy benefit  
3 manager had a contract or other  
4 arrangement with such a covered  
5 entity in the service area of such  
6 plan.

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

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

1                   agement that the listed drug is  
2                   not subject to.

3                   “(bb) The estimated average  
4                   beneficiary cost-sharing under  
5                   the plan for a 30-day supply of  
6                   the listed drug.

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

19                  “(dd) A written justification  
20                  for providing more favorable cov-  
21                  erage of the listed drug than the  
22                  generic drugs described in item  
23                  (aa).

24                  “(ee) The number of cur-  
25                  rently marketed generic drugs

1 approved under section 505(j) of  
2 the Federal Food, Drug, and  
3 Cosmetic Act pursuant to an ap-  
4 plication that references such  
5 listed drug.

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

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

1                   “(bb) The estimated average  
2 beneficiary cost-sharing under  
3 the plan for a 30-day supply of  
4 the reference product.

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

19                   “(dd) A written justification  
20 for providing more favorable cov-  
21 erage of the reference product  
22 than the biosimilar biological  
23 product described in item (aa).

24                   “(ee) The number of cur-  
25 rently marketed biosimilar bio-

1 logical products licensed under  
2 section 351(k) of the Public  
3 Health Service Act, pursuant to  
4 an application that refers to such  
5 reference product.

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

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

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

21 “(VIII) An explanation of any  
22 benefit design parameters under such  
23 plan that encourage plan enrollees to  
24 fill prescriptions at pharmacies that  
25 are an affiliate of such pharmacy ben-

1           efit manager, such as mail and spe-  
2           cialty home delivery programs, and re-  
3           tail and mail auto-refill programs.

4           “(IX) The following information:

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

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

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



1                   “(X) A list of all affiliates of the  
2                   pharmacy benefit manager.

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

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

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

1           formulary placement, or utilization  
2           management conditions on any other  
3           covered part D drugs or other pre-  
4           scription drugs, as applicable, submit  
5           to the PDP sponsor a written expla-  
6           nation of such contract or agreement.

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

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

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

1 pharmacy benefit manager, as  
2 applicable, or an individual dele-  
3 gated with the authority to sign  
4 on behalf of one of these officers,  
5 who reports directly to the offi-  
6 cer.

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

14 “(D) AUDIT RIGHTS.—

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

24 “(ii) AUDITOR.—The PDP sponsor  
25 shall have the right to select an auditor.

1           The pharmacy benefit manager shall not  
2           impose any limitations on the selection of  
3           such auditor.

4           “(iii) PROVISION OF INFORMATION.—

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

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

22          “(v) INFORMATION FROM AFFILI-  
23          ATES.—The pharmacy benefit manager  
24          shall be responsible for providing to such  
25          auditor information required to be reported

1 under subparagraph (C) or under clause  
2 (iii) of this subparagraph that is owned or  
3 held by an affiliate of such pharmacy ben-  
4 efit manager.

5 “(2) ENFORCEMENT.—

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

8 “(i) disgorge to the Secretary any  
9 amounts disgorged to the PDP sponsor by  
10 a pharmacy benefit manager under para-  
11 graph (1)(A)(v);

12 “(ii) require, in a written agreement  
13 with any pharmacy benefit manager acting  
14 on behalf of such sponsor or affiliate of  
15 such pharmacy benefit manager, that such  
16 pharmacy benefit manager or affiliate re-  
17 imburse the PDP sponsor for any civil  
18 money penalty imposed on the PDP spon-  
19 sor as a result of the failure of the phar-  
20 macy benefit manager or affiliate to meet  
21 the requirements of paragraph (1) that are  
22 applicable to the pharmacy benefit man-  
23 ager or affiliate under the agreement; and

24 “(iii) require, in a written agreement  
25 with any such pharmacy benefit manager

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

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

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

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

23 “(ii) coerce, intimidate, threaten, or  
24 interfere with the ability of an individual

1 or entity to report any such alleged viola-  
2 tions.

3 “(3) CERTIFICATION OF COMPLIANCE.—

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

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

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

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

23 “(B) modifying regulatory requirements or  
24 sub-regulatory program instruction or guidance

1 related to pharmacy payment, reimbursement,  
2 or dispensing fees.

3 “(5) STANDARD FORMATS.—

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

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

13 “(6) CONFIDENTIALITY.—

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

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



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

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

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

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

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

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

1           subparagraph (A) to the public in a manner  
2           that would identify—

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

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

11           “(7) DEFINITIONS.—For purposes of this sub-  
12           section:

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

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

21                   “(ii) acts as a contractor, principal, or  
22                   agent to such pharmacy benefit manager  
23                   or PDP sponsor, insofar as such con-  
24                   tractor, principal, or agent performs any of

1 the functions described under subpara-  
2 graph (C).

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

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

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

1 “(iii) coverage or formulary placement  
2 decisions or the volume or value of any re-  
3 ferrals or business generated between the  
4 parties to the arrangement; or

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

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

1 of whether such person or entity calls itself a  
2 ‘pharmacy benefit manager’.”.

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

7 “(F) REQUIREMENTS RELATING TO PHAR-  
8 MACY BENEFIT MANAGERS.—For plan years be-  
9 ginning on or after January 1, 2029, section  
10 1860D–12(h).”.

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

15 (4) FUNDING.—

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

24 (B) OIG.—In addition to amounts other-  
25 wise available, there is appropriated to the In-

1           spector General of the Department of Health  
2           and Human Services, out of any money in the  
3           Treasury not otherwise appropriated,  
4           \$20,000,000 for fiscal year 2026, to remain  
5           available until expended, to carry out this sub-  
6           section.

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

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

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

1           mediaries in the prescription drug supply chain,  
2           including—

3                   (i) pharmacy benefit managers;

4                   (ii) PDP sponsors offering prescrip-  
5           tion drug plans and Medicare Advantage  
6           organizations offering MA–PD plans;

7                   (iii) drug wholesalers;

8                   (iv) pharmacies;

9                   (v) manufacturers;

10                  (vi) pharmacy services administrative  
11           organizations;

12                  (vii) brokers, auditors, consultants,  
13           and other entities that—

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

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

23                   (viii) other service providers that con-  
24           tract with any of the entities described in  
25           clauses (i) through (vii) that may use

1 price-related compensation and payment  
2 structures, such as rebate aggregators (or  
3 other entities that negotiate or process  
4 price concessions on behalf of pharmacy  
5 benefit managers, plan sponsors, or phar-  
6 macies).

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

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

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

23 (E) Notable differences, if any, in the use  
24 and level of price-based compensation struc-  
25 tures over time and between different market



1 segments, such as under part D of title XVIII  
2 of the Social Security Act (42 U.S.C. 1395w–  
3 101 et seq.) and the Medicaid program under  
4 title XIX of such Act (42 U.S.C. 1396 et seq.).

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

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

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

1       (c) MEDPAC REPORTS ON AGREEMENTS WITH  
2 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-  
3 SCRIPTON DRUG PLANS AND MA–PD PLANS.—

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

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

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

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

24           (iii) any recommendations the Com-  
25 mission determines appropriate.

1 (B) FINAL REPORT.—Not later than 2  
2 years after the date on which the Commission  
3 submits the initial report under subparagraph  
4 (A), a report describing any changes with re-  
5 spect to the information described in subpara-  
6 graph (A) over time, together with any rec-  
7 ommendations the Commission determines ap-  
8 propriate.

9 (2) FUNDING.—In addition to amounts other-  
10 wise available, there is appropriated to the Medicare  
11 Payment Advisory Commission, out of any money in  
12 the Treasury not otherwise appropriated,  
13 \$1,000,000 for fiscal year 2026, to remain available  
14 until expended, to carry out this subsection.

15 **SEC. \_\_\_\_\_. EXPEDITED CONSIDERATION OF ENHANCED**  
16 **PREMIUM TAX CREDIT REFORM BILL.**

17 (a) QUALIFYING LEGISLATION.—

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

21 (2) DEFINITION.—In this section, the term  
22 “enhanced premium tax credit reform bill” means a  
23 bill or joint resolution which consists solely of legis-  
24 lative language with respect to continued health in-  
25 surance premium savings, including more significant

1 reforms, that has accumulated at least 10 cospon-  
2 sors from each of the majority party and the minor-  
3 ity party at the time it is offered.

4 (b) CONSIDERATION IN THE HOUSE OF REPRESENT-  
5 ATIVES.—

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

20 (2) PROCEEDING TO CONSIDERATION.—After  
21 the last committee authorized to consider an en-  
22 hanced premium tax credit reform bill reports it to  
23 the House of Representatives or has been discharged  
24 from its consideration, it shall be in order to move  
25 to proceed to consider the enhanced premium tax

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

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

16 (c) EXPEDITED PROCEDURE IN THE SENATE.—

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

1 tax credit reform bill was so referred. If any com-  
2 mittee to which an enhanced premium tax credit re-  
3 form bill is referred fails to report the enhanced pre-  
4 mium tax credit reform bill within that period, that  
5 committee shall be automatically discharged from  
6 consideration of the enhanced premium tax credit re-  
7 form bill, and the enhanced premium tax credit re-  
8 form bill shall be placed on the appropriate calendar.

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

1 credit reform bill are waived. The motion to proceed  
2 is not debatable. The motion is not subject to a mo-  
3 tion to postpone. A motion to reconsider the vote by  
4 which the motion is agreed to or disagreed to shall  
5 not be in order. If a motion to proceed to the consid-  
6 eration of the enhanced premium tax credit reform  
7 bill is agreed to, the enhanced premium tax credit  
8 reform bill shall remain the unfinished business until  
9 disposed of. All points of order against an enhanced  
10 premium tax credit reform bill and against consider-  
11 ation of the enhanced premium tax credit reform bill  
12 are waived.

13 (d) CONSIDERATION BY THE OTHER HOUSE.—

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

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

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

1           ceived from the other House shall supplant the  
2           enhanced premium tax credit reform bill of the  
3           receiving House.

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

8           (e) RULES TO COORDINATE ACTION WITH OTHER  
9           HOUSE.—

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

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



1 of the enhanced premium tax credit reform bill in  
2 the Senate shall be considered to be the vote on pas-  
3 sage of the enhanced premium tax credit reform bill  
4 received from the House of Representatives.

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

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

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

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

1           (2) with full recognition of the constitutional  
2       right of either House to change the rules (so far as  
3       relating to the procedure of that House) at any time,  
4       in the same manner, and to the same extent as in  
5       the case of any other rule of that House.

