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(Original Signature of Member)

119TH CONGRESS
1ST SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

Mr. FITZPATRICK introduced the following bill; which was referred to the Committee on _____

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Bipartisan Health In-

5 surance Affordability Act”.

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

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

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

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

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

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

16 “(II) AFTER 2025 FOR TAX-
17 PAYERS WHOSE HOUSEHOLD INCOME
18 DOES NOT EXCEED 150 PERCENT OF
19 POVERTY LINE.—In the case of a tax-
20 able year beginning after December
21 31, 2025, and before January 1,
22 2028, if any taxpayer’s household in-
23 come does not exceed 150 percent of
24 the poverty line for such taxable year,
25 the premium assistance amount deter-
26 mined under subsection (b)(2), with

1 respect to any coverage month, is the
2 excess of the lesser of the amount de-
3 scribed in paragraph (2)(A) or the
4 amount described in paragraph
5 (2)(B)(i), over \$5.

6 “(III) AFTER 2025 FOR TAX-
7 PAYERS WHOSE HOUSEHOLD INCOME
8 DOES NOT EXCEED 200 PERCENT OF
9 POVERTY LINE.—In the case of a tax-
10 able year beginning after December
11 31, 2025, and before January 1,
12 2028, if any taxpayer’s household in-
13 come exceeds 150 percent of the pov-
14 erty line but does not exceed 200 per-
15 cent of the poverty line for such tax-
16 able year, the premium assistance
17 amount determined under subsection
18 (b)(2), with respect to any coverage
19 month, shall be such that the pre-
20 mium assistance amount for such a
21 taxpayer shall decrease, on a sliding
22 scale in a linear manner, from the
23 amount that would result if deter-
24 mined in accordance with subclause
25 (II) to the amount that would result

1 under subsection (b)(2) by sub-
 2 stituting ‘2 percent’ for ‘the applicable
 3 percentage’ in subparagraph (B)(ii)
 4 thereof.

5 “(IV) AFTER 2025 FOR TAX-
 6 PAYERS WHOSE HOUSEHOLD INCOME
 7 EXCEEDS 200 PERCENT OF POVERTY
 8 LINE.—In the case of a taxable year
 9 beginning after December 31, 2025,
 10 and before January 1, 2028, if any
 11 taxpayer’s household income exceeds
 12 200 percent of the poverty line for
 13 such taxable year—

14 “(aa) clause (ii) shall not
 15 apply for purposes of adjusting
 16 premium percentages under this
 17 subparagraph, and

18 “(bb) the following table
 19 shall be applied in lieu of the
 20 table contained in clause (i):

“In the case of household income (expressed as a percent of poverty line) within the following in- come tier:	The initial premium percentage is-	The final premium percentage is-
200% up to 250%	2.0%	4.0%
250% up to 300%	4.0%	6.0%
300% up to 400%	6.0%	8.5%
400% up to 600%	8.5%	8.5%
600% up to 700%	8.5%	9.25%”.

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

5 (1) by striking “TEMPORARY RULE FOR 2021
6 THROUGH 2025.—In the case of” and inserting
7 “TEMPORARY RULE FOR CERTAIN YEARS.—

8 “(i) BEFORE 2026.—In the case of”,
9 and

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

11 “(ii) AFTER 2025.—In the case of a
12 taxable year beginning after December 31,
13 2025, and before January 1, 2028, sub-
14 paragraph (A) shall be applied by sub-
15 stituting ‘but does not exceed 700 percent’
16 for ‘but does not exceed 400 percent’.”.

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

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

21 (a) REDUCTION OF FRAUDULENT ENROLLMENT IN
22 QUALIFIED HEALTH PLANS.—

23 (1) PENALTIES FOR AGENTS AND BROKERS.—

24 Section 1411(h)(1) of the Patient Protection and Af-

1 fordable Care Act (42 U.S.C. 18081(h)(1)) is
2 amended—

3 (A) in subparagraph (A)—

4 (i) by redesignating clause (ii) as
5 clause (iv);

6 (ii) in clause (i)—

7 (I) in the matter preceding sub-
8 clause (I), by striking “If—” and all
9 that follows through the “such per-
10 son” in the matter following subclause
11 (II) and inserting the following: “If
12 any person (other than an agent or
13 broker) fails to provide correct infor-
14 mation under subsection (b) and such
15 failure is attributable to negligence or
16 disregard of any rules or regulations
17 of the Secretary, such person”; and

18 (II) in the second sentence, by
19 striking “For purposes” and inserting
20 the following:

21 “(iii) DEFINITIONS OF NEGLIGENCE,
22 DISREGARD.—For purposes”;

23 (iii) by inserting after clause (i) the
24 following:

- 1 “(ii) CIVIL PENALTIES FOR CERTAIN
2 VIOLATIONS BY AGENTS OR BROKERS.—If
3 any agent or broker fails to provide correct
4 information under subsection (b) or section
5 1311(c)(8) or other information, as speci-
6 fied by the Secretary, and such failure is
7 attributable to negligence or disregard of
8 any rules or regulations of the Secretary,
9 such agent or broker shall be subject, in
10 addition to any other penalties that may be
11 prescribed by law, including subparagraph
12 (C), to a civil penalty of not less than
13 \$10,000 and not more than \$50,000 with
14 respect to each individual who is the sub-
15 ject of an application for which such incor-
16 rect information is provided.”; and
17 (iv) in clause (iv) (as so redesignated),
18 by inserting “or (ii)” after “clause (i)”;
19 (B) in subparagraph (B)—
20 (i) by inserting “including subpara-
21 graph (C),” after “law,”;
22 (ii) by striking “Any person” and in-
23 serting the following:
24 “(i) IN GENERAL.—Any person”; and

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

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

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

21 “(II) PROCEDURE.—The provi-
22 sions of section 1128A of the Social
23 Security Act (other than subsections
24 (a) and (b) of such section) shall
25 apply to a civil monetary penalty

1 under subclause (I) in the same man-
2 ner as such provisions apply to a pen-
3 alty or proceeding under section
4 1128A of the Social Security Act.”;
5 and

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

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

17 (2) CONSUMER PROTECTIONS.—

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

22 “(8) AGENT- OR BROKER-ASSISTED ENROLL-
23 MENT IN QUALIFIED HEALTH PLANS IN CERTAIN
24 EXCHANGES.—

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

14 “(B) REQUIREMENTS.—The enrollment
15 verification process under subparagraph (A)
16 shall include—

17 “(i) a requirement that the agent or
18 broker provide with the new enrollment or
19 coverage change such documentation or
20 evidence (such as a standardized consent
21 form) or other sources as the Secretary de-
22 termines necessary to establish that the
23 agent or broker has the consent of the in-
24 dividual for the new enrollment or coverage
25 change;

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

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

17 “(iv) a requirement that individuals
18 are notified of any changes to enrollment,
19 coverage, the agent of record, or premium
20 tax credits in a timely manner and that
21 such notice provides plain language in-
22 structions on how individuals can cancel
23 unauthorized activity;

24 “(v) a requirement that individuals be
25 able to access their account information on

1 a website or other technology platform, as
2 defined by the Secretary, when used to
3 submit an enrollment or plan change, in
4 lieu of the Exchange website described in
5 subsection (d)(4)(C), including information
6 on the agent of record, the qualified health
7 plan, and when any changes are made to
8 the agent of record or the qualified health
9 plan, on a consumer-facing website or
10 through a toll-free telephone hotline; and

11 “(vi) a requirement that the agent or
12 broker report to the Secretary any third-
13 party marketing organization or field mar-
14 keting organization (as such terms are de-
15 fined in section 1312(e)) involved in the
16 chain of enrollment (as so defined) with re-
17 spect to such new enrollment or coverage
18 change.

19 “(C) CONSUMER PROTECTION.—The Sec-
20 retary shall ensure that the enrollment
21 verification process under subparagraph (A)
22 prioritizes continuity of coverage and care for
23 individuals, including by not disenrolling indi-
24 viduals from a qualified health plan without the
25 consent of the individual, regardless of whether

1 the broker, agent, or qualified health plan is in
2 violation of any requirement under this para-
3 graph.”.

4 (B) REQUIRED REPORTING.—Section
5 1311(c)(1) of the Patient Protection and Af-
6 fordable Care Act (42 U.S.C. 18031(c)(1)) is
7 amended—

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

10 (ii) in subparagraph (I), by striking
11 the period at the end and inserting “;
12 and”; and

13 (iii) by adding at the end the fol-
14 lowing:

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

18 (3) AUTHORITY TO REGULATE FIELD MAR-
19 KETING ORGANIZATIONS AND THIRD-PARTY MAR-
20 KETING ORGANIZATIONS.—Section 1312(e) of the
21 Patient Protection and Affordable Care Act (42
22 U.S.C. 18032(e)) is amended—

23 (A) by redesignating paragraphs (1) and
24 (2) as subclauses (I) and (II), respectively, and
25 adjusting the margins accordingly;

1 (B) in subclause (II) (as so redesignated),
2 by striking the period at the end and inserting
3 “; and”;

4 (C) by striking the subsection designation
5 and heading and all that follows through “bro-
6 kers—” and inserting the following:

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

9 “(1) AGENTS, BROKERS, AND CERTAIN MAR-
10 KETING ORGANIZATIONS.—

11 “(A) IN GENERAL.—The Secretary shall
12 establish procedures under which a State may
13 allow—

14 “(i) agents or brokers—”; and

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

16 “(ii) field marketing organizations
17 and third-party marketing organizations to
18 participate in the chain of enrollment for
19 an individual with respect to qualified
20 health plans offered through an Exchange.

21 “(B) CRITERIA.—For plan years beginning
22 on or after such date specified by the Secretary,
23 but not later than January 1, 2029, the Sec-
24 retary, by regulation, shall establish criteria for
25 States to use in determining whether to allow

1 agents and brokers to enroll individuals and
2 employers in qualified health plans as described
3 in subclause (I) of subparagraph (A)(i) and to
4 assist individuals as described in subclause (II)
5 of such subparagraph and field marketing orga-
6 nizations and third-party marketing organiza-
7 tions to participate in the chain of enrollment
8 as described in subparagraph (A)(ii). Such cri-
9 teria shall, at a minimum, require that—

10 “(i) an agent or broker act in accord-
11 ance with a standard of conduct that in-
12 cludes a duty of such agent or broker to
13 act in the best interests of the enrollee;

14 “(ii) a field marketing organization or
15 third-party marketing organization agree
16 to report the termination of an agent or
17 broker to the applicable State and the Sec-
18 retary, including the reason for termi-
19 nation; and

20 “(iii) an agent, broker, field mar-
21 keting organization, or third-party mar-
22 keting organization—

23 “(I) meet such marketing re-
24 quirements as are required by the
25 Secretary;

1 “(II) meet marketing require-
2 ments in accordance with other appli-
3 cable Federal or State law;

4 “(III) does not employ practices
5 that are confusing or misleading, as
6 determined by the Secretary;

7 “(IV) submit all marketing mate-
8 rials to the Secretary for, as deter-
9 mined appropriate by the Secretary,
10 review and approval;

11 “(V) is a licensed agent or broker
12 or meets other licensure requirements,
13 as required by the State;

14 “(VI) register with the Secretary;
15 and

16 “(VII) does not compensate any
17 individual or organization for referrals
18 or any other service relating to the
19 sale of, marketing for, or enrollment
20 in qualified health plans unless such
21 individual or organization meets the
22 criteria described in subclauses (I)
23 through (VI).

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

1 “(i) CHAIN OF ENROLLMENT.—The
2 term ‘chain of enrollment’, with respect to
3 enrollment of an individual in a qualified
4 health plan offered through an Exchange,
5 means any steps taken from marketing to
6 such individual, to such individual making
7 an enrollment decision with respect to such
8 a plan.

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

18 “(iii) MARKETING.—The term ‘mar-
19 keting’ means the use of marketing mate-
20 rials to provide information to current and
21 prospective enrollees in a qualified health
22 plan offered through an Exchange.

23 “(iv) MARKETING MATERIALS.—The
24 term ‘marketing materials’ means mate-
25 rials relating to a qualified health plan of-

1 ferred through an Exchange or benefits of-
2 ferred through an Exchange that—

3 “(I) are intended—

4 “(aa) to draw an individual’s
5 attention to such plan or the pre-
6 mium tax credits or cost-sharing
7 reductions for such plan or plans
8 offered through an Exchange;

9 “(bb) to influence an indi-
10 vidual’s decision-making process
11 when selecting a qualified health
12 plan in which to enroll; or

13 “(cc) to influence an enroll-
14 ee’s decision to stay enrolled in
15 such plan; and

16 “(II) include or address content
17 regarding the benefits, benefit struc-
18 ture, premiums, or cost sharing of
19 such plan.

20 “(v) TERMINATION.—The term ‘ter-
21 mination’, with respect to a contract or
22 business arrangement between an agent or
23 broker and a field marketing organization,
24 third-party marketing organization, or
25 health insurance issuer, means—

1 “(I) the ending of such contract
2 or business arrangement, either uni-
3 laterally by one of the parties or on
4 mutual agreement; or

5 “(II) the expiration of such con-
6 tract or business arrangement that is
7 not replaced by a substantially similar
8 agreement.

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

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

23 “(2) AUDITS.—

24 “(A) IN GENERAL.—For plan years begin-
25 ning on or after such date specified by the Sec-

1 retary, but not later than January 1, 2029, the
2 Secretary, in coordination with the States and
3 in consultation with the National Association of
4 Insurance Commissioners, shall implement a
5 process for the oversight and enforcement of
6 agent and broker compliance with this section
7 and other applicable Federal and State law (in-
8 cluding regulations) that shall include—

9 “(i) periodic audits of agents and bro-
10 kers based on—

11 “(I) complaints filed with the
12 Secretary by individuals enrolled by
13 such an agent or broker in a qualified
14 health plan offered through an Ex-
15 change;

16 “(II) an incident or enrollment
17 pattern that suggests fraud; and

18 “(III) other factors determined
19 by the Secretary; and

20 “(ii) a process under which the Sec-
21 retary shall share audit results and refer
22 potential cases of fraud to the relevant
23 State department of insurance.

24 “(B) EFFECT.—Nothing in this paragraph
25 limits or restricts any referrals made under sec-

1 tion 1311(i)(3) or any enforcement actions
2 under section 1411(h).

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

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

12 “(9) REMOVAL OF DECEASED INDIVIDUALS
13 FROM EXCHANGE PLANS.—

14 “(A) IN GENERAL.—Not later than 90
15 days after the date of the enactment of this
16 paragraph, and on a quarterly basis thereafter,
17 the Secretary shall conduct a check of the
18 Death Master File (as such term is defined in
19 section 203(d) of the Bipartisan Budget Act of
20 2013) for purposes of identifying individuals
21 enrolled in a qualified health plan through an
22 Exchange who are deceased.

23 “(B) PROCESS.—The Secretary shall—

24 “(i) establish a process to verify that
25 an individual identified pursuant to a

1 check described in subparagraph (A) is de-
2 ceased; and

3 “(ii) require an Exchange to termi-
4 nate such individual’s enrollment under a
5 qualified health plan.”.

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

11 “(4) STANDARD FOR TERMINATION FOR CER-
12 TAIN EXCHANGES.—In the case of an agent or
13 broker with an agreement in effect with an Ex-
14 change operated by the Secretary pursuant to sec-
15 tion 1321(c) to perform activities described in para-
16 graph (1)(A)(i) with respect to such Exchange, the
17 Secretary may terminate such agreement for cause
18 if the Secretary finds, based on a preponderance of
19 the evidence, that such agent or broker has violated
20 such agreement, otherwise applicable law, or any
21 other requirement applicable to such agent or
22 broker.”.

23 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIV-
24 IDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section
25 1412(c)(2) of the Patient Protection and Affordable Care

1 Act (42 U.S.C. 18082(c)(2)) is amended by adding at the
2 end the following new subparagraph:

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

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

15 The Secretary of Health and Human Services shall
16 revise section 155.410(e) of title 45, Code of Federal Reg-
17 ulations (or any successor regulation) to provide that the
18 annual open enrollment period determined for plan year
19 2026 pursuant to section 1311(c)(6) of the Patient Pro-
20 tection and Affordable Care Act (42 U.S.C. 18031(c)(6))
21 shall begin on November 1, 2025, and end on March 1,
22 2026.

23 **SEC. 5. MODERNIZING AND ENSURING PBM ACCOUNT-**
24 **ABILITY.**

25 (a) IN GENERAL.—

1 (1) PRESCRIPTION DRUG PLANS.—Section
2 1860D–12 of the Social Security Act (42 U.S.C.
3 1395w–112) is amended by adding at the end the
4 following new subsection:

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

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

18 “(A) NO INCOME OTHER THAN BONA FIDE
19 SERVICE FEES.—

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

1 of covered part D drugs, from any such en-
2 tity or individual other than bona fide serv-
3 ice fees, subject to clauses (ii) and (iii).

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

24 “(iii) CLARIFICATION ON REBATES
25 AND DISCOUNTS USED TO LOWER COSTS

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

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

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

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

1 “(vi) ADDITIONAL REQUIREMENTS.—

2 The pharmacy benefit manager shall—

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

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

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

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

1 lated to rebates, discounts, price conces-
2 sions, or net costs, terms such as—

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

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

13 “(III) ‘specialty drug’;

14 “(IV) ‘rebate’; and

15 “(V) ‘discount’;

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

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

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

4 “(C) PROVISION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 plication that references such
2 listed drug.

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

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

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

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

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

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

1 an application that refers to such
2 reference product.

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

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

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

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

1 “(IX) The following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(D) AUDIT RIGHTS.—

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

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

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

3 “(iii) PROVISION OF INFORMATION.—

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

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

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

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

4 “(2) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

1 “(3) CERTIFICATION OF COMPLIANCE.—

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

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

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

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

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

25 “(5) STANDARD FORMATS.—

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

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

10 “(6) CONFIDENTIALITY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (4) FUNDING.—

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

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

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

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

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

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

- 1 (i) pharmacy benefit managers;
- 2 (ii) PDP sponsors offering prescrip-
- 3 tion drug plans and Medicare Advantage
- 4 organizations offering MA–PD plans;
- 5 (iii) drug wholesalers;
- 6 (iv) pharmacies;
- 7 (v) manufacturers;
- 8 (vi) pharmacy services administrative
- 9 organizations;
- 10 (vii) brokers, auditors, consultants,
- 11 and other entities that—
- 12 (I) advise PDP sponsors offering
- 13 prescription drug plans and Medicare
- 14 Advantage organizations offering MA–
- 15 PD plans regarding pharmacy bene-
- 16 fits; or
- 17 (II) review PDP sponsor and
- 18 Medicare Advantage organization con-
- 19 tracts with pharmacy benefit man-
- 20 agers; and
- 21 (viii) other service providers that con-
- 22 tract with any of the entities described in
- 23 clauses (i) through (vii) that may use
- 24 price-related compensation and payment
- 25 structures, such as rebate aggregators (or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 **SEC. 6. FULL REBATE PASS THROUGH TO PLAN; EXCEP-**
13 **TION FOR INNOCENT PLAN FIDUCIARIES.**

14 (a) IN GENERAL.—Section 408(b)(2) of the Em-
15 ployee Retirement Income Security Act of 1974 (29
16 U.S.C. 1108(b)(2)) is amended—

17 (1) in subparagraph (B)(viii)—

18 (A) by redesignating subclauses (II)
19 through (IV) as subclauses (III) through (V),
20 respectively;

21 (B) in subclause (I)—

22 (i) by striking “subclause (II)” and
23 inserting “subclause (III)”; and

1 (ii) by striking “subclauses (II) and
2 (III)” and inserting “subclauses (III) and
3 (IV)”; and

4 (C) by inserting after subclause (I) the fol-
5 lowing:

6 “(II) Pursuant to subsection (a), subpara-
7 graphs (C) and (D) of section 406(a)(1) shall not
8 apply to a responsible plan fiduciary, notwith-
9 standing any failure to remit required amounts
10 under subparagraph (C)(i), if the following condi-
11 tions are met:

12 “(aa) The responsible plan fiduciary did
13 not know that the covered service provider
14 failed or would fail to make required remit-
15 tances and reasonably believed that the covered
16 service provider remitted such required
17 amounts.

18 “(bb) The responsible plan fiduciary, upon
19 discovering that the covered service provider
20 failed to remit the required amounts, requests
21 in writing that the covered service provider
22 remit such amounts.

23 “(cc) If the covered service provider fails
24 to comply with a written request described in
25 subclause (III) within 90 days of the request,

1 the responsible plan fiduciary notifies the Sec-
2 retary of the covered service provider’s failure,
3 in accordance with subclauses (III) and (IV).”;
4 and

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

6 “(C)(i)(I) For plan years beginning on or after
7 the date that is 30 months after the date of enact-
8 ment of this subparagraph (referred to in this clause
9 as the ‘effective date’), no contract or arrangement
10 or renewal or extension of a contract or arrange-
11 ment, entered into on or after the effective date, for
12 services between a covered plan and a covered serv-
13 ice provider, through a health insurance issuer offer-
14 ing group health insurance coverage, a third party
15 administrator, an entity providing pharmacy benefit
16 management services, or other entity, for pharmacy
17 benefit management services, is reasonable within
18 the meaning of this paragraph unless such entity
19 providing pharmacy benefit management services—

20 “(aa) remits 100 percent of rebates, fees,
21 alternative discounts, and other remuneration
22 received from any applicable entity that are re-
23 lated to utilization of drugs or drug spending
24 under such health plan or health insurance cov-
25 erage, to the group health plan or health insur-

1 ance issuer offering group health insurance cov-
2 erage; and

3 “(bb) does not enter into any contract for
4 pharmacy benefit management services on be-
5 half of such a plan or coverage, with an applica-
6 ble entity unless 100 percent of rebates, fees,
7 alternative discounts, and other remuneration
8 received under such contract that are related to
9 the utilization of drugs or drug spending under
10 such group health plan or health insurance cov-
11 erage are remitted to the group health plan or
12 health insurance issuer by the entity providing
13 pharmacy benefit management services.

14 “(II) Nothing in subclause (I) shall be con-
15 strued to affect the term of a contract or arrange-
16 ment, as in effect on the effective date (as described
17 in such subclause), except that such subclause shall
18 apply to any renewal or extension of such a contract
19 or arrangement entered into on or after such effec-
20 tive date, as so described.

21 “(ii) With respect to such rebates, fees, alter-
22 native discounts, and other remuneration—

23 “(I) the rebates, fees, alternative dis-
24 counts, and other remuneration under clause
25 (i)(I) shall be—

1 “(aa) remitted—

2 “(AA) on a quarterly basis, to
3 the group health plan or the group
4 health insurance issuer, not later than
5 90 days after the end of each quarter;
6 or

7 “(BB) in the case of an under-
8 payment in a remittance for a prior
9 quarter, as soon as practicable, but
10 not later than 90 days after notice of
11 the underpayment is first given;

12 “(bb) fully disclosed and enumerated
13 to the group health plan or health insur-
14 ance issuer; and

15 “(cc) returned to the covered service
16 provider for pharmacy benefit management
17 services on behalf of the group health plan
18 if any audit by a plan sponsor, issuer or a
19 third party designated by a plan sponsor,
20 indicates that the amounts received are in-
21 correct after such amounts have been paid
22 to the group health plan or health insur-
23 ance issuer;

24 “(II) the Secretary may establish proce-
25 dures for the remittance of rebates fees, alter-

1 native discounts, and other remuneration under
2 subclause (I)(aa) and the disclosure of rebates,
3 fees, alternative discounts, and other remunera-
4 tion under subclause (I)(bb); and

5 “(III) the records of such rebates, fees, al-
6 ternative discounts, and other remuneration
7 shall be available for audit by the plan sponsor,
8 issuer, or a third party designated by a plan
9 sponsor, not less than once per plan year.

10 “(iii) To ensure that an entity providing phar-
11 macy benefit management services is able to meet
12 the requirements of clause (ii)(I), a rebate
13 aggregator (or other purchasing entity designed to
14 aggregate rebates) and an applicable group pur-
15 chasing organization shall remit such rebates to the
16 entity providing pharmacy benefit management serv-
17 ices not later than 45 days after the end of each
18 quarter.

19 “(iv) A third-party administrator of a group
20 health plan, a health insurance issuer offering group
21 health insurance coverage, or a covered service pro-
22 vider for pharmacy benefit management services
23 under such health plan or health insurance coverage
24 shall make rebate contracts with rebate aggregators
25 or drug manufacturers available for audit by such

1 plan sponsor or designated third party, subject to
2 reasonable restrictions (as determined by the Sec-
3 retary) on confidentiality to prevent re-disclosure of
4 such contracts or use of such information in audits
5 for purposes unrelated to this section.

6 “(v) Audits carried out under clauses (ii)(III)
7 and (iv) shall be performed by an auditor selected by
8 the responsible plan fiduciary. Payment for such au-
9 dits shall not be made, whether directly or indirectly,
10 by the entity providing pharmacy benefit manage-
11 ment services.

12 “(vi) Nothing in this subparagraph shall be
13 construed to—

14 “(I) prohibit reasonable payments to enti-
15 ties offering pharmacy benefit management
16 services for bona fide services using a fee struc-
17 ture not described in this subparagraph, pro-
18 vided that such fees are transparent and quan-
19 tifiable to group health plans and health insur-
20 ance issuers;

21 “(II) require a third-party administrator of
22 a group health plan or covered service provider
23 for pharmacy benefit management services
24 under such health plan or health insurance cov-

1 erage to remit bona fide service fees to the
2 group health plan;

3 “(III) limit the ability of a group health
4 plan or health insurance issuer to pass through
5 rebates, fees, alternative discounts, and other
6 remuneration to the participant or beneficiary;
7 or

8 “(IV) modify the requirements for the cre-
9 ation, receipt, maintenance, or transmission of
10 protected health information under the privacy
11 regulations promulgated under the Health In-
12 surance Portability and Accountability Act of
13 1996 in part 160 and subparts A and E of part
14 164 of title 45, Code of Federal Regulations (or
15 successor regulations).

16 “(vii) For purposes of this subparagraph—

17 “(I) the terms ‘applicable entity’ and ‘ap-
18 plicable group purchasing organization’ have
19 the meanings given such terms in section
20 726(e);

21 “(II) the terms ‘covered plan’, ‘covered
22 service provider’, and ‘responsible plan fidu-
23 ciary’ have the meanings given such terms in
24 subparagraph (B); and

1 “(III) the terms ‘group health insurance
2 coverage’, ‘health insurance coverage’, and
3 ‘health insurance issuer’ have the meanings
4 given such terms in section 733.’”.

5 (b) RULE OF CONSTRUCTION.—Subclause (II)(aa) of
6 section 408(b)(2)(B)(viii) of the Employee Retirement In-
7 come Security Act of 1974 (29 U.S.C.
8 1108(b)(2)(B)(viii)), as amended by subsection (a), shall
9 not be construed to relieve or limit a responsible plan fidu-
10 ciary from the duty to monitor the practices of any covered
11 service provider that contracts with the applicable covered
12 plan, including for the purposes of ensuring the reason-
13 ableness of compensation. For purposes of this subsection,
14 the terms “covered plan”, “covered service provider”, and
15 “responsible plan fiduciary” have the meanings given such
16 terms in section 408(b)(2)(B)(ii) of the Employee Retire-
17 ment Income Security Act of 1974 (29 U.S.C.
18 1108(b)(2)(B)(ii)).

19 (c) CLARIFICATION OF COVERED SERVICE PRO-
20 VIDER.—

21 (1) SERVICES.—

22 (A) IN GENERAL.—Section
23 408(b)(2)(B)(ii)(I)(bb) of the Employee Retire-
24 ment Income Security Act of 1974 (29 U.S.C.
25 1108(b)(2)(B)(ii)(I)(bb)) is amended—

1 (i) in subitem (AA) by striking “Bro-
2 kerage services,” and inserting “Services
3 (including brokerage services),”; and

4 (ii) in subitem (BB)—

5 (I) by striking “Consulting,” and
6 inserting “Other services,”; and

7 (II) by striking “related to the
8 development or implementation of
9 plan design” and all that follows
10 through the period at the end and in-
11 serting “including any of the fol-
12 lowing: plan design, insurance or in-
13 surance product selection (including
14 vision and dental), recordkeeping,
15 medical management, benefits admin-
16 istration selection (including vision
17 and dental), stop-loss insurance, phar-
18 macy benefit management services,
19 wellness design and management serv-
20 ices, transparency tools, group pur-
21 chasing organization agreements and
22 services, participation in and services
23 from preferred vendor panels, disease
24 management, compliance services, em-
25 ployee assistance programs, or third

1 party administration services, or con-
2 sulting services related to any such
3 services.”.

4 (B) SENSE OF CONGRESS.—It is the sense
5 of Congress that the amendment made by sub-
6 paragraph (A) clarifies the existing requirement
7 of covered service providers with respect to
8 services described in section
9 408(b)(2)(B)(ii)(I)(bb)(BB) of the Employee
10 Retirement Income Security Act of 1974 (29
11 U.S.C. 1108(b)(2)(B)(ii)(I)(bb)(BB)) that were
12 in effect since the application date described in
13 section 202(e) of the No Surprises Act (Public
14 Law 116–260; 29 U.S.C. 1108 note), and does
15 not impose any additional requirement under
16 section 408(b)(2)(B) of such Act.

17 (2) CERTAIN ARRANGEMENTS FOR PHARMACY
18 BENEFIT MANAGEMENT SERVICES CONSIDERED AS
19 INDIRECT.—

20 (A) IN GENERAL.—Section 408(b)(2)(B)(i)
21 of the Employee Retirement Income Security
22 Act of 1974 (29 U.S.C. 1108(b)(2)(B)(i)) is
23 amended—

1 (i) by striking “requirements of this
2 clause” and inserting “requirements of this
3 subparagraph”; and

4 (ii) by adding at the end the fol-
5 lowing: “For purposes of applying section
6 406(a)(1)(C) with respect to a transaction
7 described under this subparagraph or sub-
8 paragraph (C), a contract or arrangement
9 for services between a covered plan and an
10 entity providing services to the plan, in-
11 cluding a health insurance issuer providing
12 health insurance coverage in connection
13 with the covered plan, in which such entity
14 contracts, in connection with such plan,
15 with a service provider for pharmacy ben-
16 efit management services, shall be consid-
17 ered an indirect furnishing of goods, serv-
18 ices, or facilities between the covered plan
19 and the service provider for pharmacy ben-
20 efit management services acting as the
21 party in interest.”.

22 (B) HEALTH INSURANCE ISSUER AND
23 HEALTH INSURANCE COVERAGE DEFINED.—
24 Section 408(b)(2)(B)(ii)(I)(aa) of such Act (29
25 U.S.C. 1108(b)(2)(B)(ii)(I)(aa)) is amended by

1 inserting before the period at the end “and the
2 terms ‘health insurance coverage’ and ‘health
3 insurance issuer’ have the meanings given such
4 terms in section 733(b)”.

5 (C) TECHNICAL AMENDMENT.—Section
6 408(b)(2)(B)(ii)(I)(aa) of the Employee Retirement
7 Income Security Act of 1974 (29 U.S.C.
8 1108(b)(2)(B)(ii)(I)(aa)) is amended by insert-
9 ing “in” after “defined”.

10 **SEC. 7. QUALIFIED EXCHANGE ENROLLEES ELIGIBLE TO**
11 **ESTABLISH HEALTH SAVINGS ACCOUNTS.**

12 (a) IN GENERAL.—Section 223 of the Internal Rev-
13 enue Code of 1986 is amended by adding at the end the
14 following new subsection:

15 “(i) QUALIFIED EXCHANGE ENROLLEES ELIGIBLE
16 TO ESTABLISH HEALTH SAVINGS ACCOUNTS.—

17 “(1) IN GENERAL.—For purposes of this sec-
18 tion, an individual who is a qualified Exchange en-
19 rollee for any month during a taxable year shall be
20 treated as an eligible individual for each of the
21 months in such taxable year and each taxable year
22 thereafter. Notwithstanding the previous sentence,
23 any individual who elects to make an advance pre-
24 mium payment under section 1412(c)(2)(C) of the
25 Patient Protection and Affordable Care Act with re-

1 spect to any month during a taxable year shall not
2 be treated as an eligible individual for such month
3 or any other month during such taxable year.

4 “(2) QUALIFIED EXCHANGE ENROLLEE.—For
5 purposes of this subsection, the term ‘qualified Ex-
6 change enrollee’ means, with respect to any month
7 during a taxable year, any individual if, as of the 1st
8 day of such month, such individual is enrolled in a
9 qualified health plan in the individual market
10 through an Exchange established under the Patient
11 Protection and Affordable Care Act that is—

12 “(A) the lowest cost bronze plan available
13 to such individual through such Exchange, or

14 “(B) in the case that, for any month dur-
15 ing the preceding taxable year, such individual
16 was enrolled in a qualified health plan in the in-
17 dividual market through such an Exchange (re-
18 ferred to in this paragraph as the ‘previous
19 plan’), such a qualified health plan for which
20 the monthly premium is lower than the monthly
21 premium that was in effect for the previous
22 plan.

23 “(3) APPLICATION OF MONTHLY LIMITATIONS
24 FOR CONTRIBUTIONS.—In the case of an individual
25 who is treated as an eligible individual under para-

1 graph (1), subsection (b)(2) shall be applied as if
2 each reference to ‘high deductible health plan’ were
3 a reference to ‘a qualified health plan in the indi-
4 vidual market that was enrolled in through an Ex-
5 change established under the Patient Protection and
6 Affordable Care Act’.

7 “(4) COORDINATION WITH CONTRIBUTIONS OF
8 PARTIAL ADVANCE PREMIUM TAX CREDIT.—The lim-
9 itation which would (but for this paragraph) apply
10 under subsection (b) for any taxable year to an indi-
11 vidual who is treated as an eligible individual under
12 paragraph (1) shall be reduced (but not below zero)
13 by the aggregate amount contributed to health sav-
14 ings accounts of such individual for such taxable
15 year under section 1412(f) of the Patient Protection
16 and Affordable Care Act (and such amount shall not
17 be allowed as a deduction under subsection (a)).

18 “(5) ALLOWING HEALTH INSURANCE TO BE
19 PURCHASED FROM ACCOUNT.—In the case of an in-
20 dividual who is treated as an eligible individual
21 under paragraph (1), subsection (d)(2) shall be ap-
22 plied without regard to subparagraphs (B) and (C)
23 thereof.”.

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

4 **SEC. 8. OPTION TO PREPAY ANNUAL PREMIUM; OPTION TO**
5 **DIRECT PARTIAL ADVANCE PAYMENT OF**
6 **PREMIUM TAX CREDIT INTO HSA.**

7 (a) OPTION TO PREPAY ANNUAL PREMIUM.—Section
8 1412(c)(2) of the Patient Protection and Affordable Care
9 Act (42 U.S.C. 18082(c)(2)) is amended—

10 (1) in subparagraph (B)(i), by inserting “, and,
11 in the case of an individual who elects to make an
12 advance premium payment under subparagraph (C),
13 further reduce such premium by \$5” before the
14 semicolon;

15 (2) by redesignating subparagraph (C), as
16 added by section 3(d), as subparagraph (D); and

17 (3) by inserting after subparagraph (B) the fol-
18 lowing new subparagraph:

19 “(C) INDIVIDUAL OPTION TO PREPAY AN-
20 NUAL PREMIUM.—Beginning with plan years
21 beginning in 2026, in the case of an individual
22 with respect to whom an advance determination
23 has been made under section 1411 that such in-
24 dividual is eligible for a premium tax credit
25 under section 36B of the Internal Revenue

1 Code of 1986, if the premium assistance
2 amount under subsection (b)(2) of such section
3 is determined with respect to such individual in
4 accordance with subsection (b)(3)(A)(iii)(II) of
5 such section, such individual may elect to make
6 an advance premium payment to the issuer of
7 the qualified health plan in which such indi-
8 vidual is enrolled in an amount equal to \$5
9 multiplied by—

10 “(i) in the case that the advance de-
11 termination of eligibility was made during
12 the annual open enrollment period for such
13 plan year, 12; or

14 “(ii) in the case that the advance de-
15 termination of eligibility was made during
16 an open enrollment period other than the
17 annual open enrollment period for such
18 plan year, the number of months remain-
19 ing in such plan year.”.

20 (b) OPTION TO DIRECT PARTIAL ADVANCE PAYMENT
21 OF PREMIUM TAX CREDIT INTO HSA.—Section 1412 of
22 the Patient Protection and Affordable Care Act (42
23 U.S.C. 18082) is amended—

24 (1) in subsection (c)(2)—

1 (A) in subparagraph (A), by striking
2 “The” and inserting “Subject to subsection (f),
3 the”; and

4 (B) in subparagraph (B), by inserting
5 “(including such a payment made in accordance
6 with subsection (f))” after “an advance pay-
7 ment”; and

8 (2) by adding at the end the following new sub-
9 section:

10 “(f) OPTION TO DIRECT PARTIAL ADVANCE PAY-
11 MENT OF PREMIUM TAX CREDIT TO HSA.—

12 “(1) IN GENERAL.—Beginning with plan years
13 beginning in 2026, at the election of an eligible en-
14 rolled individual described in paragraph (2), the ad-
15 vance payment of the premium tax credit allowed
16 under section 36B of the Internal Revenue Code of
17 1986 shall be made as follows:

18 “(A) The Secretary of the Treasury shall
19 make advance payment of 50 percent of such
20 premium tax credit to the issuer of a qualified
21 health plan on a monthly basis (or such other
22 periodic basis as the Secretary may provide).

23 “(B) The Secretary of the Treasury shall
24 make advance payment of 50 percent of such
25 premium tax credit into a health savings ac-

1 count (as defined in section 223(d) of the Inter-
2 nal Revenue Code of 1986) of such individual
3 (as designated by such individual) on the same
4 basis provided for under subparagraph (A), but
5 only to the extent that the aggregate amount of
6 such payments does not exceed the limitation
7 under section 223(b) of such Code (determined
8 without regard to this subsection) which is ap-
9 plicable to such individual for the taxable year
10 in which such payments are made.

11 “(2) ELIGIBLE ENROLLED INDIVIDUAL.—For
12 purposes of this subsection, the term ‘eligible en-
13 rolled individual’ means, with respect to a plan year
14 (starting with 2026), an individual—

15 “(A) with respect to whom an advance de-
16 termination has been made under section 1411
17 that such individual is eligible for a premium
18 tax credit under section 36B of the Internal
19 Revenue Code of 1986;

20 “(B) who is, for the first month of such
21 plan year, a qualified Exchange enrollee (as de-
22 fined in section 223(i) of the Internal Revenue
23 Code of 1986); and

1 “(C) who does not elect to make an ad-
2 vance premium payment under subsection
3 (c)(2)(C).”.

4 **SEC. 9. REPORT.**

5 Not later than one year after the date of the enact-
6 ment of this Act, the Secretary of the Treasury and the
7 Secretary of Health and Human Services shall jointly sub-
8 mit to Congress a report on the implementation of sections
9 7 and 8 and any recommendations on expanding accessi-
10 bility of health savings accounts.