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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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Bipartisan Health Insurance Affordability Act''.

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

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

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

(2) by striking ''TEMPORARY PERCENTAGES FOR 2021 THROUGH 2025.—In the case of'' and inserting ''TEMPORARY RULES FOR CERTAIN YEARS.—

''(I) BEFORE 2026.—In the case of'', and

(3) by adding at the end the following:

''(II) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 150 PERCENT OF POVERTY LINE.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's household income does not exceed 150 percent of the poverty line for such taxable year, the premium assistance amount determined under subsection (b)(2), with

respect to any coverage month, is the excess of the lesser of the amount described in paragraph (2)(A) or the amount described in paragraph (2)(B)(i), over $5.

''(III) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME DOES NOT EXCEED 200 PERCENT OF POVERTY LINE.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's household income exceeds 150 percent of the poverty line but does not exceed 200 percent of the poverty line for such taxable year, the premium assistance amount determined under subsection (b)(2), with respect to any coverage month, shall be such that the premium assistance amount for such a taxpayer shall decrease, on a sliding scale in a linear manner, from the amount that would result if determined in accordance with subclause (II) to the amount that would result

under subsection (b)(2) by substituting '2 percent' for 'the applicable percentage' in subparagraph (B)(ii) thereof.

''(IV) AFTER 2025 FOR TAXPAYERS WHOSE HOUSEHOLD INCOME EXCEEDS 200 PERCENT OF POVERTY LINE.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, if any taxpayer's household income exceeds 200 percent of the poverty line for such taxable year—

''(aa) clause (ii) shall not apply for purposes of adjusting premium percentages under this subparagraph, and

''(bb) the following table shall be applied in lieu of the table contained in clause (i):

''In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
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%''.

(b) EXTENSION AND MODIFICATION OF RULE TO ALLOW CREDIT TO TAXPAYERS WHOSE HOUSEHOLD INCOME EXCEEDS 400 PERCENT OF POVERTY LINE.—Section 36B(c)(1)(E) of such Code is amended—

(1) by striking ''TEMPORARY RULE FOR 2021 THROUGH 2025.—In the case of'' and inserting ''TEMPORARY RULE FOR CERTAIN YEARS.—

''(i) BEFORE 2026.—In the case of'', and

(2) by adding at the end the following:

''(ii) AFTER 2025.—In the case of a taxable year beginning after December 31, 2025, and before January 1, 2028, subparagraph (A) shall be applied by substituting 'but does not exceed 700 percent' for 'but does not exceed 400 percent'.''.

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

SEC. 3. GUARDRAILS TO PREVENT FRAUD IN EXCHANGES.

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

(1) PENALTIES FOR AGENTS AND BROKERS.—Section 1411(h)(1) of the Patient Protection and Af-

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

(A) in subparagraph (A)—

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

(ii) in clause (i)—

(I) in the matter preceding subclause (I), by striking ''If—'' and all that follows through the ''such person'' in the matter following subclause (II) and inserting the following: ''If any person (other than an agent or broker) fails to provide correct information under subsection (b) and such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such person''; and

(II) in the second sentence, by striking ''For purposes'' and inserting the following:

''(iii) DEFINITIONS OF NEGLIGENCE, DISREGARD.—For purposes'';

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

''(ii) CIVIL PENALTIES FOR CERTAIN VIOLATIONS BY AGENTS OR BROKERS.—If any agent or broker fails to provide correct information under subsection (b) or section 1311(c)(8) or other information, as specified by the Secretary, and such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such agent or broker shall be subject, in addition to any other penalties that may be prescribed by law, including subparagraph (C), to a civil penalty of not less than $10,000 and not more than $50,000 with respect to each individual who is the subject of an application for which such incorrect information is provided.''; and

(iv) in clause (iv) (as so redesignated), by inserting ''or (ii)'' after ''clause (i)'';

(B) in subparagraph (B)—

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

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

''(i) IN GENERAL.—Any person''; and

(iii) by adding at the end the following:

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

''(I) IN GENERAL.—Any agent or broker who knowingly provides false or fraudulent information under subsection (b) or section 1311(c)(8), or other false or fraudulent information as part of an application for enrollment in a qualified health plan offered through an Exchange, as specified by the Secretary, shall be subject, in addition to any other penalties that may be prescribed by law, including subparagraph (C), to a civil penalty of not more than $200,000 with respect to each individual who is the subject of an application for which such false or fraudulent information is provided.

''(II) PROCEDURE.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty

under subclause (I) in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.''; and

(C) by adding at the end the following:

''(C) CRIMINAL PENALTIES.—Any agent or broker who knowingly and willfully provides false or fraudulent information under subsection (b) or section 1311(c)(8), or other false or fraudulent information as part of an application for enrollment in a qualified health plan offered through an Exchange, as specified by the Secretary, shall be fined under title 18, United States Code, imprisoned for not more than 10 years, or both.''.

(2) CONSUMER PROTECTIONS.—

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

''(8) AGENT- OR BROKER-ASSISTED ENROLLMENT IN QUALIFIED HEALTH PLANS IN CERTAIN EXCHANGES.—

"(A) IN GENERAL.—For plan years beginning on or after such date specified by the Secretary, but not later than January 1, 2029, in the case of an Exchange that the Secretary operates pursuant to section 1321(c)(1), the Secretary shall establish a verification process for new enrollments of individuals in, and changes in coverage for individuals under, a qualified health plan offered through such Exchange, which are submitted by an agent or broker in accordance with section 1312(e) and for which the agent or broker is eligible to receive a commission.

"(B) REQUIREMENTS.—The enrollment verification process under subparagraph (A) shall include—

"(i) a requirement that the agent or broker provide with the new enrollment or coverage change such documentation or evidence (such as a standardized consent form) or other sources as the Secretary determines necessary to establish that the agent or broker has the consent of the individual for the new enrollment or coverage change;

''(ii) a requirement that any commissions due to a broker or agent for such new enrollment or coverage change are paid after the enrollee has resolved all inconsistencies in accordance with paragraphs (3) and (4) of section 1411(e);

''(iii) a requirement that the information required under clause (i) and, as applicable, the date on which inconsistencies are resolved as described in clause (ii), is accessible to the applicable qualified health plan through a database or other resource, as determined by the Secretary, so that any commissions due to a broker or agent for such enrollment can be effectuated at the appropriate time;

''(iv) a requirement that individuals are notified of any changes to enrollment, coverage, the agent of record, or premium tax credits in a timely manner and that such notice provides plain language instructions on how individuals can cancel unauthorized activity;

''(v) a requirement that individuals be able to access their account information on

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

''(vi) a requirement that the agent or broker report to the Secretary any third-party marketing organization or field marketing organization (as such terms are defined in section 1312(e)) involved in the chain of enrollment (as so defined) with respect to such new enrollment or coverage change.

''(C) CONSUMER PROTECTION.—The Secretary shall ensure that the enrollment verification process under subparagraph (A) prioritizes continuity of coverage and care for individuals, including by not disenrolling individuals from a qualified health plan without the consent of the individual, regardless of whether

the broker, agent, or qualified health plan is in violation of any requirement under this paragraph.''.

(B) REQUIRED REPORTING.—Section 1311(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)) is amended—

(i) in subparagraph (H), by striking ''and'' at the end;

(ii) in subparagraph (I), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(J) report to the Secretary the termination (as defined in section 1312(e)(1)(C)) of an issuer.''.

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

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

(B) in subclause (II) (as so redesignated), by striking the period at the end and inserting ''; and'';

(C) by striking the subsection designation and heading and all that follows through ''brokers—'' and inserting the following:

''(e) REGULATION OF AGENTS, BROKERS, AND CERTAIN MARKETING ORGANIZATIONS.—

''(1) AGENTS, BROKERS, AND CERTAIN MARKETING ORGANIZATIONS.—

''(A) IN GENERAL.—The Secretary shall establish procedures under which a State may allow—

''(i) agents or brokers—''; and

(D) by adding at the end the following:

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

''(B) CRITERIA.—For plan years beginning on or after such date specified by the Secretary, but not later than January 1, 2029, the Secretary, by regulation, shall establish criteria for States to use in determining whether to allow

agents and brokers to enroll individuals and employers in qualified health plans as described in subclause (I) of subparagraph (A)(i) and to assist individuals as described in subclause (II) of such subparagraph and field marketing organizations and third-party marketing organizations to participate in the chain of enrollment as described in subparagraph (A)(ii). Such criteria shall, at a minimum, require that—

''(i) an agent or broker act in accordance with a standard of conduct that includes a duty of such agent or broker to act in the best interests of the enrollee;

''(ii) a field marketing organization or third-party marketing organization agree to report the termination of an agent or broker to the applicable State and the Secretary, including the reason for termination; and

''(iii) an agent, broker, field marketing organization, or third-party marketing organization—

''(I) meet such marketing requirements as are required by the Secretary;

''(II) meet marketing requirements in accordance with other applicable Federal or State law;

''(III) does not employ practices that are confusing or misleading, as determined by the Secretary;

''(IV) submit all marketing materials to the Secretary for, as determined appropriate by the Secretary, review and approval;

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

''(VI) register with the Secretary; and

''(VII) does not compensate any individual or organization for referrals or any other service relating to the sale of, marketing for, or enrollment in qualified health plans unless such individual or organization meets the criteria described in subclauses (I) through (VI).

''(C) DEFINITIONS.—In this paragraph:

''(i) CHAIN OF ENROLLMENT.—The term 'chain of enrollment', with respect to enrollment of an individual in a qualified health plan offered through an Exchange, means any steps taken from marketing to such individual, to such individual making an enrollment decision with respect to such a plan.

''(ii) FIELD MARKETING ORGANIZATION.—The term 'field marketing organization' means an organization or individual that directly employs or contracts with agents and brokers, or contracts with carriers, to provide functions relating to enrollment of individuals in qualified health plans offered through an Exchange as part of the chain of enrollment.

''(iii) MARKETING.—The term 'marketing' means the use of marketing materials to provide information to current and prospective enrollees in a qualified health plan offered through an Exchange.

''(iv) MARKETING MATERIALS.—The term 'marketing materials' means materials relating to a qualified health plan of-

fered through an Exchange or benefits offered through an Exchange that—

''(I) are intended—

''(aa) to draw an individual's attention to such plan or the premium tax credits or cost-sharing reductions for such plan or plans offered through an Exchange;

''(bb) to influence an individual's decision-making process when selecting a qualified health plan in which to enroll; or

''(cc) to influence an enrollee's decision to stay enrolled in such plan; and

''(II) include or address content regarding the benefits, benefit structure, premiums, or cost sharing of such plan.

''(v) TERMINATION.—The term 'termination', with respect to a contract or business arrangement between an agent or broker and a field marketing organization, third-party marketing organization, or health insurance issuer, means—

''(I) the ending of such contract or business arrangement, either unilaterally by one of the parties or on mutual agreement; or

''(II) the expiration of such contract or business arrangement that is not replaced by a substantially similar agreement.

''(vi) THIRD-PARTY MARKETING ORGANIZATION.—The term 'third-party marketing organization' means an organization or individual that is compensated to perform lead generation, marketing, or sales relating to enrollment of individuals in qualified health plans offered through an Exchange as part of the chain of enrollment.''.

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

''(2) AUDITS.—

''(A) IN GENERAL.—For plan years beginning on or after such date specified by the Sec-

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

''(i) periodic audits of agents and brokers based on—

''(I) complaints filed with the Secretary by individuals enrolled by such an agent or broker in a qualified health plan offered through an Exchange;

''(II) an incident or enrollment pattern that suggests fraud; and

''(III) other factors determined by the Secretary; and

''(ii) a process under which the Secretary shall share audit results and refer potential cases of fraud to the relevant State department of insurance.

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

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

''(3) LIST.—The Secretary shall develop a process to regularly provide to qualified health plans, Exchanges, and States a list of suspended and terminated agents and brokers.''.

(b) REMOVAL OF DECEASED INDIVIDUALS FROM EXCHANGE PLANS.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(9) REMOVAL OF DECEASED INDIVIDUALS FROM EXCHANGE PLANS.—

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

''(B) PROCESS.—The Secretary shall—

''(i) establish a process to verify that an individual identified pursuant to a

check described in subparagraph (A) is deceased; and

''(ii) require an Exchange to terminate such individual's enrollment under a qualified health plan.''.

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

''(4) STANDARD FOR TERMINATION FOR CERTAIN EXCHANGES.—In the case of an agent or broker with an agreement in effect with an Exchange operated by the Secretary pursuant to section 1321(c) to perform activities described in paragraph (1)(A)(i) with respect to such Exchange, the Secretary may terminate such agreement for cause if the Secretary finds, based on a preponderance of the evidence, that such agent or broker has violated such agreement, otherwise applicable law, or any other requirement applicable to such agent or broker.''.

(d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIVIDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section 1412(c)(2) of the Patient Protection and Affordable Care

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

''(C) EXCHANGE RESPONSIBILITIES.—Beginning January 1, 2027, if an Exchange is notified under paragraph (1) of an advance determination under section 1411 with respect to the eligibility of an individual for a premium tax credit under section 36B of the Internal Revenue Code of 1986, the Exchange shall, prior to enrolling such individual in a qualified health plan, clearly notify such individual of the amount of such tax credit.''.

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

The Secretary of Health and Human Services shall revise section 155.410(e) of title 45, Code of Federal Regulations (or any successor regulation) to provide that the annual open enrollment period determined for plan year 2026 pursuant to section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) shall begin on November 1, 2025, and end on March 1, 2026.

SEC. 5. MODERNIZING AND ENSURING PBM ACCOUNTABILITY.

(a) IN GENERAL.—

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

''(h) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2029:

''(1) AGREEMENTS WITH PHARMACY BENEFIT MANAGERS.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that any pharmacy benefit manager acting on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager, and any affiliates of such pharmacy benefit manager, as applicable, agree to meet the following requirements:

''(A) NO INCOME OTHER THAN BONA FIDE SERVICE FEES.—

''(i) IN GENERAL.—The pharmacy benefit manager and any affiliate of such pharmacy benefit manager shall not derive any remuneration with respect to any services provided on behalf of any entity or individual, in connection with the utilization

of covered part D drugs, from any such entity or individual other than bona fide service fees, subject to clauses (ii) and (iii).

''(ii) INCENTIVE PAYMENTS.—For the purposes of this subsection, an incentive payment (as determined by the Secretary) paid by a PDP sponsor to a pharmacy benefit manager that is performing services on behalf of such sponsor shall be deemed a 'bona fide service fee' (even if such payment does not otherwise meet the definition of such term under paragraph (7)(B)) if such payment is a flat dollar amount, is consistent with fair market value (as specified by the Secretary), is related to services actually performed by the pharmacy benefit manager or affiliate of such pharmacy benefit manager, on behalf of the PDP sponsor making such payment, in connection with the utilization of covered part D drugs, and meets additional requirements, if any, as determined appropriate by the Secretary.

''(iii) CLARIFICATION ON REBATES AND DISCOUNTS USED TO LOWER COSTS

FOR COVERED PART D DRUGS.—Rebates, discounts, and other price concessions received by a pharmacy benefit manager or an affiliate of a pharmacy benefit manager from manufacturers, even if such price concessions are calculated as a percentage of a drug's price, shall not be considered a violation of the requirements of clause (i) if they are fully passed through to a PDP sponsor and are compliant with all regulatory and subregulatory requirements related to direct and indirect remuneration for manufacturer rebates under this part, including in cases where a PDP sponsor is acting as a pharmacy benefit manager on behalf of a prescription drug plan offered by such PDP sponsor.

''(iv) EVALUATION OF REMUNERATION ARRANGEMENTS.—Components of subsets of remuneration arrangements (such as fees or other forms of compensation paid to or retained by the pharmacy benefit manager or affiliate of such pharmacy benefit manager), as determined appropriate by the Secretary, between pharmacy ben-

efit managers or affiliates of such pharmacy benefit managers, as applicable, and other entities involved in the dispensing or utilization of covered part D drugs (including PDP sponsors, manufacturers, pharmacies, and other entities as determined appropriate by the Secretary) shall be subject to review by the Secretary, in consultation with the Office of the Inspector General of the Department of Health and Human Services, as determined appropriate by the Secretary. The Secretary, in consultation with the Office of the Inspector General, shall review whether remuneration under such arrangements is consistent with fair market value (as specified by the Secretary) through reviews and assessments of such remuneration, as determined appropriate.

''(v) DISGORGEMENT.—The pharmacy benefit manager shall disgorge any remuneration paid to such pharmacy benefit manager or an affiliate of such pharmacy benefit manager in violation of this subparagraph to the PDP sponsor.

''(vi) ADDITIONAL REQUIREMENTS.—The pharmacy benefit manager shall—

''(I) enter into a written agreement with any affiliate of such pharmacy benefit manager, under which the affiliate shall identify and disgorge any remuneration described in clause (v) to the pharmacy benefit manager; and

''(II) attest, subject to any requirements determined appropriate by the Secretary, that the pharmacy benefit manager has entered into a written agreement described in subclause (I) with any relevant affiliate of the pharmacy benefit manager.

''(B) TRANSPARENCY REGARDING GUARANTEES AND COST PERFORMANCE EVALUATIONS.—The pharmacy benefit manager shall—

''(i) define, interpret, and apply, in a fully transparent and consistent manner for purposes of calculating or otherwise evaluating pharmacy benefit manager performance against pricing guarantees or similar cost performance measurements re-

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

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

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

''(III) 'specialty drug';

''(IV) 'rebate'; and

''(V) 'discount';

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

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

culate and provide a wholesale acquisition cost-based equivalent to the pricing guarantee or other cost performance measure.

''(C) PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Not later than July 1 of each year, beginning in 2029, the pharmacy benefit manager shall submit to the PDP sponsor, and to the Secretary, a report, in accordance with this subparagraph, and shall make such report available to such sponsor at no cost to such sponsor in a format specified by the Secretary under paragraph (5). Each such report shall include, with respect to such PDP sponsor and each plan offered by such sponsor, the following information with respect to the previous plan year:

''(I) A list of all drugs covered by the plan that were dispensed including, with respect to each such drug—

''(aa) the brand name, generic or non-proprietary name, and National Drug Code;

''(bb) the number of plan enrollees for whom the drug was

dispensed, the total number of prescription claims for the drug (including original prescriptions and refills, counted as separate claims), and the total number of dosage units of the drug dispensed;

''(cc) the number of prescription claims described in item (bb) by each type of dispensing channel through which the drug was dispensed, including retail, mail order, specialty pharmacy, long term care pharmacy, home infusion pharmacy, or other types of pharmacies or providers;

''(dd) the average wholesale acquisition cost, listed as cost per day's supply, cost per dosage unit, and cost per typical course of treatment (as applicable);

''(ee) the average wholesale price for the drug, listed as price per day's supply, price per dosage unit, and price per typical

course of treatment (as applicable);

''(ff) the total out-of-pocket spending by plan enrollees on such drug after application of any benefits under the plan, including plan enrollee spending through copayments, coinsurance, and deductibles;

''(gg) total rebates paid by the manufacturer on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

''(hh) all other direct or indirect remuneration on the drug as reported under the Detailed DIR Report (or any successor report) submitted by such sponsor to the Centers for Medicare & Medicaid Services;

''(ii) the average pharmacy reimbursement amount paid by

the plan for the drug in the aggregate and disaggregated by dispensing channel identified in item (cc);

''(jj) the average National Average Drug Acquisition Cost (NADAC); and

''(kk) total manufacturer-derived revenue, inclusive of bona fide service fees, attributable to the drug and retained by the pharmacy benefit manager and any affiliate of such pharmacy benefit manager.

''(II) In the case of a pharmacy benefit manager that has an affiliate that is a retail, mail order, or specialty pharmacy, with respect to drugs covered by such plan that were dispensed, the following information:

''(aa) The percentage of total prescriptions that were dispensed by pharmacies that are an affiliate of the pharmacy benefit manager for each drug.

''(bb) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are not an affiliate of the pharmacy benefit manager and that are included in the pharmacy network of such plan.

''(cc) The interquartile range of the total combined costs paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply for each drug dispensed by pharmacies that are an affiliate of the pharmacy benefit manager and that are included in the pharmacy network of such plan.

''(dd) The lowest total combined cost paid by the plan and plan enrollees, per dosage unit,

per course of treatment, per 30-day supply, and per 90-day supply, for each drug that is available from any pharmacy included in the pharmacy network of such plan.

''(ee) The difference between the average acquisition cost of the affiliate, such as a pharmacy or other entity that acquires prescription drugs, that initially acquires the drug and the amount reported under subclause (I)(jj) for each drug.

''(ff) A list inclusive of the brand name, generic or non-proprietary name, and National Drug Code of covered part D drugs subject to an agreement with a covered entity under section 340B of the Public Health Service Act for which the pharmacy benefit manager or an affiliate of the pharmacy benefit manager had a contract or other

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

''(III) Where a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (referred to in this subclause as the 'listed drug') is covered by the plan, the following information:

''(aa) A list of currently marketed generic drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act pursuant to an application that references such listed drug that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the listed drug, or are subject to utilization management that the listed drug is not subject to.

''(bb) The estimated average beneficiary cost-sharing under

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

''(cc) Where a generic drug listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the listed drug, the estimated average cost-sharing that a beneficiary would have paid for a 30-day supply of each of the generic drugs described in item (aa), had the plan provided coverage for such drugs on the same formulary tier as the listed drug.

''(dd) A written justification for providing more favorable coverage of the listed drug than the generic drugs described in item (aa).

''(ee) The number of currently marketed generic drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act pursuant to an ap-

plication that references such listed drug.

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

''(aa) A list of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health Service Act pursuant to an application that refers to such reference product that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the reference product, or are subject to utilization management that the reference product is not subject to.

''(bb) The estimated average beneficiary cost-sharing under the plan for a 30-day supply of the reference product.

''(cc) Where a biosimilar biological product listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the reference product, the estimated average cost-sharing that a beneficiary would have paid for a 30-day supply of each of the biosimilar biological products described in item (aa), had the plan provided coverage for such products on the same formulary tier as the reference product.

''(dd) A written justification for providing more favorable coverage of the reference product than the biosimilar biological product described in item (aa).

''(ee) The number of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health Service Act, pursuant to

an application that refers to such reference product.

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

''(VI) The total amount retained by the pharmacy benefit manager or an affiliate of such pharmacy benefit manager in revenue related to utilization of covered part D drugs under that plan, inclusive of bona fide service fees.

''(VII) The total spending on covered part D drugs net of rebates, fees, discounts, or other direct and indirect remuneration by the plan.

''(VIII) An explanation of any benefit design parameters under such plan that encourage plan enrollees to fill prescriptions at pharmacies that are an affiliate of such pharmacy benefit manager, such as mail and specialty home delivery programs, and retail and mail auto-refill programs.

''(IX) The following information:

''(aa) A list of all brokers, consultants, advisors, and auditors that receive compensation from the pharmacy benefit manager or an affiliate of such pharmacy benefit manager for referrals, consulting, auditing, or other services offered to PDP sponsors related to pharmacy benefit management services.

''(bb) The amount of compensation provided by such pharmacy benefit manager or affiliate to each such broker, consultant, advisor, and auditor.

''(cc) The methodology for calculating the amount of compensation provided by such pharmacy benefit manager or affiliate, for each such broker, consultant, advisor, and auditor.

''(X) A list of all affiliates of the pharmacy benefit manager.

''(XI) A summary document submitted in a standardized template developed by the Secretary that includes such information described in subclauses (I) through (X).

''(ii) WRITTEN EXPLANATION OF CONTRACTS OR AGREEMENTS WITH DRUG MANUFACTURERS.—

''(I) IN GENERAL.—The pharmacy benefit manager shall, not later than 30 days after the finalization of any contract or agreement between such pharmacy benefit manager or an affiliate of such pharmacy benefit manager and a drug manufacturer (or subsidiary, agent, or entity affiliated with such drug manufacturer) that makes rebates, discounts, payments, or other financial incentives related to one or more covered part D drugs or other prescription drugs, as applicable, of the manufacturer directly or indirectly contingent upon coverage, formulary placement, or utilization management conditions on any other

covered part D drugs or other prescription drugs, as applicable, submit to the PDP sponsor a written explanation of such contract or agreement.

''(II) REQUIREMENTS.—A written explanation under subclause (I) shall—

''(aa) include the manufacturer subject to the contract or agreement, all covered part D drugs and other prescription drugs, as applicable, subject to the contract or agreement and the manufacturers of such drugs, and a high-level description of the terms of such contract or agreement and how such terms apply to such drugs; and

''(bb) be certified by the Chief Executive Officer, Chief Financial Officer, or General Counsel of such pharmacy benefit manager, or affiliate of such pharmacy benefit manager, as applicable, or an individual dele-

gated with the authority to sign on behalf of one of these officers, who reports directly to the officer.

''(III) DEFINITION OF OTHER PRESCRIPTION DRUGS.—For purposes of this clause, the term 'other prescription drugs' means prescription drugs covered as supplemental benefits under this part or prescription drugs paid outside of this part.

''(D) AUDIT RIGHTS.—

''(i) IN GENERAL.—Not less than once a year, at the request of the PDP sponsor, the pharmacy benefit manager shall allow for an audit of the pharmacy benefit manager to ensure compliance with all terms and conditions under the written agreement described in this paragraph and the accuracy of information reported under subparagraph (C).

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

impose any limitations on the selection of such auditor.

''(iii) PROVISION OF INFORMATION.—The pharmacy benefit manager shall make available to such auditor all records, data, contracts, and other information necessary to confirm the accuracy of information provided under subparagraph (C), subject to reasonable restrictions on how such information must be reported to prevent redisclosure of such information.

''(iv) TIMING.—The pharmacy benefit manager must provide information under clause (iii) and other information, data, and records relevant to the audit to such auditor within 6 months of the initiation of the audit and respond to requests for additional information from such auditor within 30 days after the request for additional information.

''(v) INFORMATION FROM AFFILIATES.—The pharmacy benefit manager shall be responsible for providing to such auditor information required to be reported under subparagraph (C) or under clause

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

''(2) ENFORCEMENT.—

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

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

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

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

iate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate be subject to punitive remedies for breach of contract for failure to comply with the requirements applicable under paragraph (1).

''(B) REPORTING OF ALLEGED VIOLATIONS.—The Secretary shall make available and maintain a mechanism for manufacturers, PDP sponsors, pharmacies, and other entities that have contractual relationships with pharmacy benefit managers or affiliates of such pharmacy benefit managers to report, on a confidential basis, alleged violations of paragraph (1)(A) or subparagraph (C).

''(C) ANTI-RETALIATION AND ANTI-COERCION.—Consistent with applicable Federal or State law, a PDP sponsor shall not—

''(i) retaliate against an individual or entity for reporting an alleged violation under subparagraph (B); or

''(ii) coerce, intimidate, threaten, or interfere with the ability of an individual or entity to report any such alleged violations.

''(3) CERTIFICATION OF COMPLIANCE.—

''(A) IN GENERAL.—Each PDP sponsor shall furnish to the Secretary (at a time and in a manner specified by the Secretary) an annual certification of compliance with this subsection, as well as such information as the Secretary determines necessary to carry out this subsection.

''(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

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

''(A) prohibiting flat dispensing fees or reimbursement or payment for ingredient costs (including customary, industry-standard discounts directly related to drug acquisition that are retained by pharmacies or wholesalers) to entities that acquire or dispense prescription drugs; or

''(B) modifying regulatory requirements or sub-regulatory program instruction or guidance related to pharmacy payment, reimbursement, or dispensing fees.

''(5) STANDARD FORMATS.—

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

"(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

"(6) CONFIDENTIALITY.—

"(A) IN GENERAL.—Information disclosed by a pharmacy benefit manager, an affiliate of a pharmacy benefit manager, a PDP sponsor, or a pharmacy under this subsection that is not otherwise publicly available or available for purchase shall not be disclosed by the Secretary or a PDP sponsor receiving the information, except that the Secretary may disclose the information for the following purposes:

"(i) As the Secretary determines necessary to carry out this part.

"(ii) To permit the Comptroller General to review the information provided.

''(iii) To permit the Director of the Congressional Budget Office to review the information provided.

''(iv) To permit the Executive Director of the Medicare Payment Advisory Commission to review the information provided.

''(v) To the Attorney General for the purposes of conducting oversight and enforcement under this title.

''(vi) To the Inspector General of the Department of Health and Human Services in accordance with its authorities under the Inspector General Act of 1978 (section 406 of title 5, United States Code), and other applicable statutes.

''(B) RESTRICTION ON USE OF INFORMATION.—The Secretary, the Comptroller General, the Director of the Congressional Budget Office, and the Executive Director of the Medicare Payment Advisory Commission shall not report on or disclose information disclosed pursuant to subparagraph (A) to the public in a manner that would identify—

''(i) a specific pharmacy benefit manager, affiliate, pharmacy, manufacturer, wholesaler, PDP sponsor, or plan; or

''(ii) contract prices, rebates, discounts, or other remuneration for specific drugs in a manner that may allow the identification of specific contracting parties or of such specific drugs.

''(7) DEFINITIONS.—For purposes of this subsection:

''(A) AFFILIATE.—The term 'affiliate' means, with respect to any pharmacy benefit manager or PDP sponsor, any entity that, directly or indirectly—

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

''(ii) acts as a contractor, principal, or agent to such pharmacy benefit manager or PDP sponsor, insofar as such contractor, principal, or agent performs any of the functions described under subparagraph (C).

''(B) BONA FIDE SERVICE FEE.—The term 'bona fide service fee' means a fee that is reflective of the fair market value (as specified by the Secretary, through notice and comment rulemaking) for a bona fide, itemized service actually performed on behalf of an entity, that the entity would otherwise perform (or contract for) in the absence of the service arrangement and that is not passed on in whole or in part to a client or customer, whether or not the entity takes title to the drug. Such fee must be a flat dollar amount and shall not be directly or indirectly based on, or contingent upon—

''(i) drug price, such as wholesale acquisition cost or drug benchmark price (such as average wholesale price);

''(ii) the amount of discounts, rebates, fees, or other direct or indirect remuneration with respect to covered part D drugs dispensed to enrollees in a prescription drug plan, except as permitted pursuant to paragraph (1)(A)(ii);

''(iii) coverage or formulary placement decisions or the volume or value of any re-

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

"(iv) any other amounts or methodologies prohibited by the Secretary.

"(C) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a PDP sponsor or prescription drug plan, or manages the prescription drug benefits provided by such sponsor or plan, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered part D drugs, or the provision of related services. Such term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a 'pharmacy benefit manager'.".

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

"(F) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2029, section 1860D–12(h).".

(3) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this subsection.

(4) FUNDING.—

(A) SECRETARY.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $113,000,000 for fiscal year 2026, to remain available until expended, to carry out this subsection.

(B) OIG.—In addition to amounts otherwise available, there is appropriated to the Inspector General of the Department of Health and Human Services, out of any money in the

Treasury not otherwise appropriated, $20,000,000 for fiscal year 2026, to remain available until expended, to carry out this subsection.

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

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study describing the use of compensation and payment structures related to a prescription drug's price within the retail prescription drug supply chain in part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.). Such study shall summarize information from Federal agencies and industry experts, to the extent available, with respect to the following:

(A) The type, magnitude, other features (such as the pricing benchmarks used), and prevalence of compensation and payment structures related to a prescription drug's price, such as calculating fee amounts as a percentage of a prescription drug's price, between intermediaries in the prescription drug supply chain, including—

(i) pharmacy benefit managers;

(ii) PDP sponsors offering prescription drug plans and Medicare Advantage organizations offering MA–PD plans;

(iii) drug wholesalers;

(iv) pharmacies;

(v) manufacturers;

(vi) pharmacy services administrative organizations;

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

(I) advise PDP sponsors offering prescription drug plans and Medicare Advantage organizations offering MA–PD plans regarding pharmacy benefits; or

(II) review PDP sponsor and Medicare Advantage organization contracts with pharmacy benefit managers; and

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

other entities that negotiate or process price concessions on behalf of pharmacy benefit managers, plan sponsors, or pharmacies).

(B) The primary business models and compensation structures for each category of intermediary described in subparagraph (A).

(C) Variation in price-related compensation structures between affiliated entities (such as entities with common ownership, either full or partial, and subsidiary relationships) and unaffiliated entities.

(D) Potential conflicts of interest among contracting entities related to the use of prescription drug price-related compensation structures, such as the potential for fees or other payments set as a percentage of a prescription drug's price to advantage formulary selection, distribution, or purchasing of prescription drugs with higher prices.

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

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

(F) The effects of drug price-related compensation structures and alternative compensation structures on Federal health care programs and program beneficiaries, including with respect to cost-sharing, premiums, Federal outlays, biosimilar and generic drug adoption and utilization, drug shortage risks, and the potential for fees set as a percentage of a drug's price to advantage the formulary selection, distribution, or purchasing of drugs with higher prices.

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

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

(c) MEDPAC REPORTS ON AGREEMENTS WITH PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.—

(1) IN GENERAL.—The Medicare Payment Advisory Commission shall submit to Congress the following reports:

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

(i) a description of trends and patterns, including relevant averages, totals, and other figures for the types of information submitted;

(ii) an analysis of any differences in agreements and their effects on plan enrollee out-of-pocket spending and average pharmacy reimbursement, and other impacts; and

(iii) any recommendations the Commission determines appropriate.

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

(A), a report describing any changes with respect to the information described in subparagraph (A) over time, together with any recommendations the Commission determines appropriate.

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

SEC. 6. FULL REBATE PASS THROUGH TO PLAN; EXCEPTION FOR INNOCENT PLAN FIDUCIARIES.

(a) IN GENERAL.—Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)) is amended—

(1) in subparagraph (B)(viii)—

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

(B) in subclause (I)—

(i) by striking ''subclause (II)'' and inserting ''subclause (III)''; and

(ii) by striking ''subclauses (II) and (III)'' and inserting ''subclauses (III) and (IV)''; and

(C) by inserting after subclause (I) the following:

''(II) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure to remit required amounts under subparagraph (C)(i), if the following conditions are met:

''(aa) The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required remittances and reasonably believed that the covered service provider remitted such required amounts.

''(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to remit the required amounts, requests in writing that the covered service provider remit such amounts.

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

the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (III) and (IV).''; and

(2) by adding at the end the following:

''(C)(i)(I) For plan years beginning on or after the date that is 30 months after the date of enactment of this subparagraph (referred to in this clause as the 'effective date'), no contract or arrangement or renewal or extension of a contract or arrangement, entered into on or after the effective date, for services between a covered plan and a covered service provider, through a health insurance issuer offering group health insurance coverage, a third party administrator, an entity providing pharmacy benefit management services, or other entity, for pharmacy benefit management services, is reasonable within the meaning of this paragraph unless such entity providing pharmacy benefit management services—

''(aa) remits 100 percent of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to utilization of drugs or drug spending under such health plan or health insurance coverage, to the group health plan or health insur-

ance issuer offering group health insurance coverage; and

''(bb) does not enter into any contract for pharmacy benefit management services on behalf of such a plan or coverage, with an applicable entity unless 100 percent of rebates, fees, alternative discounts, and other remuneration received under such contract that are related to the utilization of drugs or drug spending under such group health plan or health insurance coverage are remitted to the group health plan or health insurance issuer by the entity providing pharmacy benefit management services.

''(II) Nothing in subclause (I) shall be construed to affect the term of a contract or arrangement, as in effect on the effective date (as described in such subclause), except that such subclause shall apply to any renewal or extension of such a contract or arrangement entered into on or after such effective date, as so described.

''(ii) With respect to such rebates, fees, alternative discounts, and other remuneration—

''(I) the rebates, fees, alternative discounts, and other remuneration under clause (i)(I) shall be—

''(aa) remitted—

''(AA) on a quarterly basis, to the group health plan or the group health insurance issuer, not later than 90 days after the end of each quarter; or

''(BB) in the case of an underpayment in a remittance for a prior quarter, as soon as practicable, but not later than 90 days after notice of the underpayment is first given;

''(bb) fully disclosed and enumerated to the group health plan or health insurance issuer; and

''(cc) returned to the covered service provider for pharmacy benefit management services on behalf of the group health plan if any audit by a plan sponsor, issuer or a third party designated by a plan sponsor, indicates that the amounts received are incorrect after such amounts have been paid to the group health plan or health insurance issuer;

''(II) the Secretary may establish procedures for the remittance of rebates fees, alter-

native discounts, and other remuneration under subclause (I)(aa) and the disclosure of rebates, fees, alternative discounts, and other remuneration under subclause (I)(bb); and

''(III) the records of such rebates, fees, alternative discounts, and other remuneration shall be available for audit by the plan sponsor, issuer, or a third party designated by a plan sponsor, not less than once per plan year.

''(iii) To ensure that an entity providing pharmacy benefit management services is able to meet the requirements of clause (ii)(I), a rebate aggregator (or other purchasing entity designed to aggregate rebates) and an applicable group purchasing organization shall remit such rebates to the entity providing pharmacy benefit management services not later than 45 days after the end of each quarter.

''(iv) A third-party administrator of a group health plan, a health insurance issuer offering group health insurance coverage, or a covered service provider for pharmacy benefit management services under such health plan or health insurance coverage shall make rebate contracts with rebate aggregators or drug manufacturers available for audit by such

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

''(v) Audits carried out under clauses (ii)(III) and (iv) shall be performed by an auditor selected by the responsible plan fiduciary. Payment for such audits shall not be made, whether directly or indirectly, by the entity providing pharmacy benefit management services.

''(vi) Nothing in this subparagraph shall be construed to—

''(I) prohibit reasonable payments to entities offering pharmacy benefit management services for bona fide services using a fee structure not described in this subparagraph, provided that such fees are transparent and quantifiable to group health plans and health insurance issuers;

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

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

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

''(IV) modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations).

''(vii) For purposes of this subparagraph—

''(I) the terms 'applicable entity' and 'applicable group purchasing organization' have the meanings given such terms in section 726(e);

''(II) the terms 'covered plan', 'covered service provider', and 'responsible plan fiduciary' have the meanings given such terms in subparagraph (B); and

"(III) the terms 'group health insurance coverage', 'health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 733.".

(b) RULE OF CONSTRUCTION.—Subclause (II)(aa) of section 408(b)(2)(B)(viii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)(viii)), as amended by subsection (a), shall not be construed to relieve or limit a responsible plan fiduciary from the duty to monitor the practices of any covered service provider that contracts with the applicable covered plan, including for the purposes of ensuring the reasonableness of compensation. For purposes of this subsection, the terms ''covered plan'', ''covered service provider'', and ''responsible plan fiduciary'' have the meanings given such terms in section 408(b)(2)(B)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)(ii)).

(c) CLARIFICATION OF COVERED SERVICE PROVIDER.—

(1) SERVICES.—

(A) IN GENERAL.—Section 408(b)(2)(B)(ii)(I)(bb) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)(ii)(I)(bb)) is amended—

(i) in subitem (AA) by striking ''Brokerage services,'' and inserting ''Services (including brokerage services),''; and

(ii) in subitem (BB)—

(I) by striking ''Consulting,'' and inserting ''Other services,''; and

(II) by striking ''related to the development or implementation of plan design'' and all that follows through the period at the end and inserting ''including any of the following: plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third

party administration services, or consulting services related to any such services.''.

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

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

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

(i) by striking ''requirements of this clause'' and inserting ''requirements of this subparagraph''; and

(ii) by adding at the end the following: ''For purposes of applying section 406(a)(1)(C) with respect to a transaction described under this subparagraph or subparagraph (C), a contract or arrangement for services between a covered plan and an entity providing services to the plan, including a health insurance issuer providing health insurance coverage in connection with the covered plan, in which such entity contracts, in connection with such plan, with a service provider for pharmacy benefit management services, shall be considered an indirect furnishing of goods, services, or facilities between the covered plan and the service provider for pharmacy benefit management services acting as the party in interest.''.

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

inserting before the period at the end ''and the terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms in section 733(b)''.

(C) TECHNICAL AMENDMENT.—Section 408(b)(2)(B)(ii)(I)(aa) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)(ii)(I)(aa)) is amended by inserting ''in'' after ''defined''.

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

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(i) QUALIFIED EXCHANGE ENROLLEES ELIGIBLE TO ESTABLISH HEALTH SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—For purposes of this section, an individual who is a qualified Exchange enrollee for any month during a taxable year shall be treated as an eligible individual for each of the months in such taxable year and each taxable year thereafter. Notwithstanding the previous sentence, any individual who elects to make an advance premium payment under section 1412(c)(2)(C) of the Patient Protection and Affordable Care Act with re-

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

''(2) QUALIFIED EXCHANGE ENROLLEE.—For purposes of this subsection, the term 'qualified Exchange enrollee' means, with respect to any month during a taxable year, any individual if, as of the 1st day of such month, such individual is enrolled in a qualified health plan in the individual market through an Exchange established under the Patient Protection and Affordable Care Act that is—

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

''(B) in the case that, for any month during the preceding taxable year, such individual was enrolled in a qualified health plan in the individual market through such an Exchange (referred to in this paragraph as the 'previous plan'), such a qualified health plan for which the monthly premium is lower than the monthly premium that was in effect for the previous plan.

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

graph (1), subsection (b)(2) shall be applied as if each reference to 'high deductible health plan' were a reference to 'a qualified health plan in the individual market that was enrolled in through an Exchange established under the Patient Protection and Affordable Care Act'.

''(4) COORDINATION WITH CONTRIBUTIONS OF PARTIAL ADVANCE PREMIUM TAX CREDIT.—The limitation which would (but for this paragraph) apply under subsection (b) for any taxable year to an individual who is treated as an eligible individual under paragraph (1) shall be reduced (but not below zero) by the aggregate amount contributed to health savings accounts of such individual for such taxable year under section 1412(f) of the Patient Protection and Affordable Care Act (and such amount shall not be allowed as a deduction under subsection (a)).

''(5) ALLOWING HEALTH INSURANCE TO BE PURCHASED FROM ACCOUNT.—In the case of an individual who is treated as an eligible individual under paragraph (1), subsection (d)(2) shall be applied without regard to subparagraphs (B) and (C) thereof.''.

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

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

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

(1) in subparagraph (B)(i), by inserting ", and, in the case of an individual who elects to make an advance premium payment under subparagraph (C), further reduce such premium by $5" before the semicolon;

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

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) INDIVIDUAL OPTION TO PREPAY ANNUAL PREMIUM.—Beginning with plan years beginning in 2026, in the case of an individual with respect to whom an advance determination has been made under section 1411 that such individual is eligible for a premium tax credit under section 36B of the Internal Revenue

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

''(i) in the case that the advance determination of eligibility was made during the annual open enrollment period for such plan year, 12; or

''(ii) in the case that the advance determination of eligibility was made during an open enrollment period other than the annual open enrollment period for such plan year, the number of months remaining in such plan year.''.

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

(1) in subsection (c)(2)—

(A) in subparagraph (A), by striking ''The'' and inserting ''Subject to subsection (f), the''; and

(B) in subparagraph (B), by inserting ''(including such a payment made in accordance with subsection (f))'' after ''an advance payment''; and

(2) by adding at the end the following new subsection:

''(f) OPTION TO DIRECT PARTIAL ADVANCE PAYMENT OF PREMIUM TAX CREDIT TO HSA.—

''(1) IN GENERAL.—Beginning with plan years beginning in 2026, at the election of an eligible enrolled individual described in paragraph (2), the advance payment of the premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 shall be made as follows:

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

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

count (as defined in section 223(d) of the Internal Revenue Code of 1986) of such individual (as designated by such individual) on the same basis provided for under subparagraph (A), but only to the extent that the aggregate amount of such payments does not exceed the limitation under section 223(b) of such Code (determined without regard to this subsection) which is applicable to such individual for the taxable year in which such payments are made.

''(2) ELIGIBLE ENROLLED INDIVIDUAL.—For purposes of this subsection, the term 'eligible enrolled individual' means, with respect to a plan year (starting with 2026), an individual—

''(A) with respect to whom an advance determination has been made under section 1411 that such individual is eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986;

''(B) who is, for the first month of such plan year, a qualified Exchange enrollee (as defined in section 223(i) of the Internal Revenue Code of 1986); and

"(C) who does not elect to make an advance premium payment under subsection (c)(2)(C).".

SEC. 9. REPORT.

Not later than one year after the date of the enactment of this Act, the Secretary of the Treasury and the Secretary of Health and Human Services shall jointly submit to Congress a report on the implementation of sections 7 and 8 and any recommendations on expanding accessibility of health savings accounts.