

119TH CONGRESS
1ST SESSION

H. R. 6501

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

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 9, 2025

Mr. FITZPATRICK (for himself, Mr. GOLDEN of Maine, Mr. BACON, Mr. SUOZZI, Mr. BRESNAHAN, Mr. DAVIS of North Carolina, Ms. MALLIOTAKIS, Ms. PEREZ, Mr. LAWLER, Ms. SALAZAR, Mr. MACKENZIE, Mr. KEAN, Mr. VAN DREW, Mr. VALADAO, Mr. CISCOMANI, and Mr. LALOTA) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Bipartisan Health In-
3 surance Affordability Act”.

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

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

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

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

16 “(I) BEFORE 2026.—In the case
17 of”, and

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

19 “(II) AFTER 2025 FOR TAX-
20 PAYERS WHOSE HOUSEHOLD INCOME
21 DOES NOT EXCEED 150 PERCENT OF
22 POVERTY LINE.—In the case of a tax-
23 able year beginning after December
24 31, 2025, and before January 1,
25 2028, if any taxpayer’s household in-
26 come does not exceed 150 percent of

1 the poverty line for such taxable year,
2 the premium assistance amount deter-
3 mined under subsection (b)(2), with
4 respect to any coverage month, is the
5 excess of the lesser of the amount de-
6 scribed in paragraph (2)(A) or the
7 amount described in paragraph
8 (2)(B)(i), over \$5.

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

1 amount that would result if deter-
2 mined in accordance with subclause
3 (II) to the amount that would result
4 under subsection (b)(2) by sub-
5 stituting ‘2 percent’ for ‘the applicable
6 percentage’ in subparagraph (B)(ii)
7 thereof.

8 “(IV) AFTER 2025 FOR TAX-
9 PAYERS WHOSE HOUSEHOLD INCOME
10 EXCEEDS 200 percent OF POVERTY
11 LINE.—In the case of a taxable year
12 beginning after December 31, 2025,
13 and before January 1, 2028, if any
14 taxpayer’s household income exceeds
15 200 percent of the poverty line for
16 such taxable year—

17 “(aa) clause (ii) shall not
18 apply for purposes of adjusting
19 premium percentages under this
20 subparagraph, and

21 “(bb) the following table
22 shall be applied in lieu of the
23 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%”.

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.

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

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

4 (1) PENALTIES FOR AGENTS AND BROKERS.—

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

8 (A) in subparagraph (A)—

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

11 (ii) in clause (i)—

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

23 (II) in the second sentence, by
24 striking “For purposes” and inserting
25 the following:

1 “(iii) DEFINITIONS OF NEGLIGENCE,
2 DISREGARD.—For purposes”;

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

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

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

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

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

3 “(i) IN GENERAL.—Any person”; and
4 (iii) by adding at the end the fol-
5 lowing:

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

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

24 “(II) PROCEDURE.—The provi-
25 sions of section 1128A of the Social

1 Security Act (other than subsections
2 (a) and (b) of such section) shall
3 apply to a civil monetary penalty
4 under subclause (I) in the same man-
5 ner as such provisions apply to a pen-
6 alty or proceeding under section
7 1128A of the Social Security Act.”;
8 and

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

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

20 (2) CONSUMER PROTECTIONS.—

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

1 “(8) AGENT- OR BROKER-ASSISTED ENROLL-
2 MENT IN QUALIFIED HEALTH PLANS IN CERTAIN
3 EXCHANGES.—

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

17 “(B) REQUIREMENTS.—The enrollment
18 verification process under subparagraph (A)
19 shall include—

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

1 agent or broker has the consent of the in-
2 dividual for the new enrollment or coverage
3 change;

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

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

20 “(iv) a requirement that individuals
21 are notified of any changes to enrollment,
22 coverage, the agent of record, or premium
23 tax credits in a timely manner and that
24 such notice provides plain language in-

1 instructions on how individuals can cancel
2 unauthorized activity;

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

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

23 “(C) CONSUMER PROTECTION.—The Sec-
24 retary shall ensure that the enrollment
25 verification process under subparagraph (A)

1 prioritizes continuity of coverage and care for
 2 individuals, including by not disenrolling indi-
 3 viduals from a qualified health plan without the
 4 consent of the individual, regardless of whether
 5 the broker, agent, or qualified health plan is in
 6 violation of any requirement under this para-
 7 graph.”.

8 (B) REQUIRED REPORTING.—Section
 9 1311(c)(1) of the Patient Protection and Af-
 10 fordable Care Act (42 U.S.C. 18031(c)(1)) is
 11 amended—

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

14 (ii) in subparagraph (I), by striking
 15 the period at the end and inserting “;
 16 and”; and

17 (iii) by adding at the end the fol-
 18 lowing:

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

22 (3) AUTHORITY TO REGULATE FIELD MAR-
 23 KETING ORGANIZATIONS AND THIRD-PARTY MAR-
 24 KETING ORGANIZATIONS.—Section 1312(e) of the

1 Patient Protection and Affordable Care Act (42
2 U.S.C. 18032(e)) is amended—

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

6 (B) in subclause (II) (as so redesignated),
7 by striking the period at the end and inserting
8 “; and”;

9 (C) by striking the subsection designation
10 and heading and all that follows through “bro-
11 kers—” and inserting the following:

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

14 “(1) AGENTS, BROKERS, AND CERTAIN MAR-
15 KETING ORGANIZATIONS.—

16 “(A) IN GENERAL.—The Secretary shall
17 establish procedures under which a State may
18 allow—

19 “(i) agents or brokers—”; and

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

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

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

15 “(i) an agent or broker act in accord-
16 ance with a standard of conduct that in-
17 cludes a duty of such agent or broker to
18 act in the best interests of the enrollee;

19 “(ii) a field marketing organization or
20 third-party marketing organization agree
21 to report the termination of an agent or
22 broker to the applicable State and the Sec-
23 retary, including the reason for termi-
24 nation; and

1 “(iii) an agent, broker, field mar-
2 keting organization, or third-party mar-
3 keting organization—

4 “(I) meet such marketing re-
5 quirements as are required by the
6 Secretary;

7 “(II) meet marketing require-
8 ments in accordance with other appli-
9 cable Federal or State law;

10 “(III) does not employ practices
11 that are confusing or misleading, as
12 determined by the Secretary;

13 “(IV) submit all marketing mate-
14 rials to the Secretary for, as deter-
15 mined appropriate by the Secretary,
16 review and approval;

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

20 “(VI) register with the Secretary;
21 and

22 “(VII) does not compensate any
23 individual or organization for referrals
24 or any other service relating to the
25 sale of, marketing for, or enrollment

1 in qualified health plans unless such
2 individual or organization meets the
3 criteria described in subclauses (I)
4 through (VI).

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

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

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

23 “(iii) MARKETING.—The term ‘mar-
24 keting’ means the use of marketing mate-
25 rials to provide information to current and

1 prospective enrollees in a qualified health
2 plan offered through an Exchange.

3 “(iv) **MARKETING MATERIALS.**—The
4 term ‘marketing materials’ means mate-
5 rials relating to a qualified health plan of-
6 fered through an Exchange or benefits of-
7 fered through an Exchange that—

8 “(I) are intended—

9 “(aa) to draw an individual’s
10 attention to such plan or the pre-
11 mium tax credits or cost-sharing
12 reductions for such plan or plans
13 offered through an Exchange;

14 “(bb) to influence an indi-
15 vidual’s decision-making process
16 when selecting a qualified health
17 plan in which to enroll; or

18 “(cc) to influence an enroll-
19 ee’s decision to stay enrolled in
20 such plan; and

21 “(II) include or address content
22 regarding the benefits, benefit struc-
23 ture, premiums, or cost sharing of
24 such plan.

1 “(v) TERMINATION.—The term ‘ter-
2 mination’, with respect to a contract or
3 business arrangement between an agent or
4 broker and a field marketing organization,
5 third-party marketing organization, or
6 health insurance issuer, means—

7 “(I) the ending of such contract
8 or business arrangement, either uni-
9 laterally by one of the parties or on
10 mutual agreement; or

11 “(II) the expiration of such con-
12 tract or business arrangement that is
13 not replaced by a substantially similar
14 agreement.

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

24 (4) TRANSPARENCY.—Section 1312(e) of the
25 Patient Protection and Affordable Care Act (42

1 U.S.C. 18032(e)), as amended by paragraph (3), is
2 further amended by adding at the end the following
3 new paragraphs:

4 “(2) AUDITS.—

5 “(A) IN GENERAL.—For plan years begin-
6 ning on or after such date specified by the Sec-
7 retary, but not later than January 1, 2029, the
8 Secretary, in coordination with the States and
9 in consultation with the National Association of
10 Insurance Commissioners, shall implement a
11 process for the oversight and enforcement of
12 agent and broker compliance with this section
13 and other applicable Federal and State law (in-
14 cluding regulations) that shall include—

15 “(i) periodic audits of agents and bro-
16 kers based on—

17 “(I) complaints filed with the
18 Secretary by individuals enrolled by
19 such an agent or broker in a qualified
20 health plan offered through an Ex-
21 change;

22 “(II) an incident or enrollment
23 pattern that suggests fraud; and

24 “(III) other factors determined
25 by the Secretary; and

1 “(ii) a process under which the Sec-
 2 retary shall share audit results and refer
 3 potential cases of fraud to the relevant
 4 State department of insurance.

5 “(B) EFFECT.—Nothing in this paragraph
 6 limits or restricts any referrals made under sec-
 7 tion 1311(i)(3) or any enforcement actions
 8 under section 1411(h).

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

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

18 “(9) REMOVAL OF DECEASED INDIVIDUALS
 19 FROM EXCHANGE PLANS.—

20 “(A) IN GENERAL.—Not later than 90
 21 days after the date of the enactment of this
 22 paragraph, and on a quarterly basis thereafter,
 23 the Secretary shall conduct a check of the
 24 Death Master File (as such term is defined in
 25 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

1 such agreement, otherwise applicable law, or any
 2 other requirement applicable to such agent or
 3 broker.”.

4 (d) REQUIREMENT FOR EXCHANGE TO NOTIFY INDIVIDUALS OF VALUE OF PREMIUM TAX CREDITS.—Section
 5 1412(c)(2) of the Patient Protection and Affordable Care
 6 Act (42 U.S.C. 18082(c)(2)) is amended by adding at the
 7 end the following new subparagraph:

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

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

21 The Secretary of Health and Human Services shall
 22 revise section 155.410(e) of title 45, Code of Federal Reg-
 23 ulations (or any successor regulation) to provide that the
 24 annual open enrollment period determined for plan year
 25 2026 pursuant to section 1311(c)(6) of the Patient Pro-

1 tection and Affordable Care Act (42 U.S.C. 18031(c)(6))
2 shall begin on November 1, 2025, and end on March 1,
3 2026.

4 **SEC. 5. MODERNIZING AND ENSURING PBM ACCOUNT-**
5 **ABILITY.**

6 (a) IN GENERAL.—

7 (1) PRESCRIPTION DRUG PLANS.—Section
8 1860D–12 of the Social Security Act (42 U.S.C.
9 1395w–112) is amended by adding at the end the
10 following new subsection:

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

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

24 “(A) NO INCOME OTHER THAN BONA FIDE
25 SERVICE FEES.—

1 “(i) IN GENERAL.—The pharmacy
2 benefit manager and any affiliate of such
3 pharmacy benefit manager shall not derive
4 any remuneration with respect to any serv-
5 ices provided on behalf of any entity or in-
6 dividual, in connection with the utilization
7 of covered part D drugs, from any such en-
8 tity or individual other than bona fide serv-
9 ice fees, subject to clauses (ii) and (iii).

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

1 in connection with the utilization of cov-
2 ered part D drugs, and meets additional
3 requirements, if any, as determined appro-
4 priate by the Secretary.

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

24 “(iv) EVALUATION OF REMUNERATION
25 ARRANGEMENTS.—Components of subsets

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

1 “(v) DISGORGEMENT.—The pharmacy
2 benefit manager shall disgorge any remuneration paid to such pharmacy benefit
3 manager or an affiliate of such pharmacy
4 benefit manager in violation of this sub-
5 paragraph to the PDP sponsor.
6

7 “(vi) ADDITIONAL REQUIREMENTS.—
8 The pharmacy benefit manager shall—

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

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

23 “(B) TRANSPARENCY REGARDING GUARAN-
24 TEES AND COST PERFORMANCE EVALUA-
25 TIONS.—The pharmacy benefit manager shall—

1 “(i) define, interpret, and apply, in a
2 fully transparent and consistent manner
3 for purposes of calculating or otherwise
4 evaluating pharmacy benefit manager per-
5 formance against pricing guarantees or
6 similar cost performance measurements re-
7 lated to rebates, discounts, price conces-
8 sions, or net costs, terms such as—

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

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

19 “(III) ‘specialty drug’;

20 “(IV) ‘rebate’; and

21 “(V) ‘discount’;

22 “(ii) identify any drugs, claims, or
23 price concessions excluded from any pric-
24 ing guarantee or other cost performance

1 measure in a clear and consistent manner;
2 and

3 “(iii) where a pricing guarantee or
4 other cost performance measure is based
5 on a pricing benchmark other than the
6 wholesale acquisition cost (as defined in
7 section 1847A(c)(6)(B)) of a drug, cal-
8 culate and provide a wholesale acquisition
9 cost-based equivalent to the pricing guar-
10 antee or other cost performance measure.

11 “(C) PROVISION OF INFORMATION.—

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

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

4 “(aa) the brand name, ge-
5 neric or non-proprietary name,
6 and National Drug Code;

7 “(bb) the number of plan
8 enrollees for whom the drug was
9 dispensed, the total number of
10 prescription claims for the drug
11 (including original prescriptions
12 and refills, counted as separate
13 claims), and the total number of
14 dosage units of the drug dis-
15 pensed;

16 “(cc) the number of pre-
17 scription claims described in item
18 (bb) by each type of dispensing
19 channel through which the drug
20 was dispensed, including retail,
21 mail order, specialty pharmacy,
22 long term care pharmacy, home
23 infusion pharmacy, or other types
24 of pharmacies or providers;

1 “(dd) the average wholesale
2 acquisition cost, listed as cost per
3 day’s supply, cost per dosage
4 unit, and cost per typical course
5 of treatment (as applicable);

6 “(ee) the average wholesale
7 price for the drug, listed as price
8 per day’s supply, price per dos-
9 age unit, and price per typical
10 course of treatment (as applica-
11 ble);

12 “(ff) the total out-of-pocket
13 spending by plan enrollees on
14 such drug after application of
15 any benefits under the plan, in-
16 cluding plan enrollee spending
17 through copayments, coinsurance,
18 and deductibles;

19 “(gg) total rebates paid by
20 the manufacturer on the drug as
21 reported under the Detailed DIR
22 Report (or any successor report)
23 submitted by such sponsor to the
24 Centers for Medicare & Medicaid
25 Services;

1 “(hh) all other direct or in-
2 direct remuneration on the drug
3 as reported under the Detailed
4 DIR Report (or any successor re-
5 port) submitted by such sponsor
6 to the Centers for Medicare &
7 Medicaid Services;

8 “(ii) the average pharmacy
9 reimbursement amount paid by
10 the plan for the drug in the ag-
11 gregate and disaggregated by dis-
12 pensing channel identified in item
13 (cc);

14 “(jj) the average National
15 Average Drug Acquisition Cost
16 (NADAC); and

17 “(kk) total manufacturer-de-
18 rived revenue, inclusive of bona
19 fide service fees, attributable to
20 the drug and retained by the
21 pharmacy benefit manager and
22 any affiliate of such pharmacy
23 benefit manager.

24 “(II) In the case of a pharmacy
25 benefit manager that has an affiliate

1 that is a retail, mail order, or spe-
2 cialty pharmacy, with respect to drugs
3 covered by such plan that were dis-
4 pensed, the following information:

5 “(aa) The percentage of
6 total prescriptions that were dis-
7 pensed by pharmacies that are an
8 affiliate of the pharmacy benefit
9 manager for each drug.

10 “(bb) The interquartile
11 range of the total combined costs
12 paid by the plan and plan enroll-
13 ees, per dosage unit, per course
14 of treatment, per 30-day supply,
15 and per 90-day supply for each
16 drug dispensed by pharmacies
17 that are not an affiliate of the
18 pharmacy benefit manager and
19 that are included in the phar-
20 macy network of such plan.

21 “(cc) The interquartile
22 range of the total combined costs
23 paid by the plan and plan enroll-
24 ees, per dosage unit, per course
25 of treatment, per 30-day supply,

1 and per 90-day supply for each
2 drug dispensed by pharmacies
3 that are an affiliate of the phar-
4 macy benefit manager and that
5 are included in the pharmacy
6 network of such plan.

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

16 “(ee) The difference between
17 the average acquisition cost of
18 the affiliate, such as a pharmacy
19 or other entity that acquires pre-
20 scription drugs, that initially ac-
21 quires the drug and the amount
22 reported under subclause (I)(jj)
23 for each drug.

24 “(ff) A list inclusive of the
25 brand name, generic or non-pro-

1 proprietary name, and National
2 Drug Code of covered part D
3 drugs subject to an agreement
4 with a covered entity under sec-
5 tion 340B of the Public Health
6 Service Act for which the phar-
7 macy benefit manager or an affil-
8 iate of the pharmacy benefit
9 manager had a contract or other
10 arrangement with such a covered
11 entity in the service area of such
12 plan.

13 “(III) Where a drug approved
14 under section 505(c) of the Federal
15 Food, Drug, and Cosmetic Act (re-
16 ferred to in this subclause as the ‘list-
17 ed drug’) is covered by the plan, the
18 following information:

19 “(aa) A list of currently
20 marketed generic drugs approved
21 under section 505(j) of the Fed-
22 eral Food, Drug, and Cosmetic
23 Act pursuant to an application
24 that references such listed drug
25 that are not covered by the plan,

1 are covered on the same for-
2 mulary tier or a formulary tier
3 typically associated with higher
4 cost-sharing than the listed drug,
5 or are subject to utilization man-
6 agement that the listed drug is
7 not subject to.

8 “(bb) The estimated average
9 beneficiary cost-sharing under
10 the plan for a 30-day supply of
11 the listed drug.

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

24 “(dd) A written justification
25 for providing more favorable cov-

1 erage of the listed drug than the
2 generic drugs described in item
3 (aa).

4 “(ee) The number of cur-
5 rently marketed generic drugs
6 approved under section 505(j) of
7 the Federal Food, Drug, and
8 Cosmetic Act pursuant to an ap-
9 plication that references such
10 listed drug.

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

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

1 reference product, or are subject
2 to utilization management that
3 the reference product is not sub-
4 ject to.

5 “(bb) The estimated average
6 beneficiary cost-sharing under
7 the plan for a 30-day supply of
8 the reference product.

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

23 “(dd) A written justification
24 for providing more favorable cov-
25 erage of the reference product

1 than the biosimilar biological
2 product described in item (aa).

3 “(ee) The number of cur-
4 rently marketed biosimilar bio-
5 logical products licensed under
6 section 351(k) of the Public
7 Health Service Act, pursuant to
8 an application that refers to such
9 reference product.

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

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

21 “(VII) The total spending on cov-
22 ered part D drugs net of rebates, fees,
23 discounts, or other direct and indirect
24 remuneration by the plan.

1 “(VIII) An explanation of any
2 benefit design parameters under such
3 plan that encourage plan enrollees to
4 fill prescriptions at pharmacies that
5 are an affiliate of such pharmacy ben-
6 efit manager, such as mail and spe-
7 cialty home delivery programs, and re-
8 tail and mail auto-refill programs.

9 “(IX) The following information:

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

20 “(bb) The amount of com-
21 pensation provided by such phar-
22 macy benefit manager or affiliate
23 to each such broker, consultant,
24 advisor, and auditor.

1 “(cc) The methodology for
2 calculating the amount of com-
3 pensation provided by such phar-
4 macy benefit manager or affil-
5 iate, for each such broker, con-
6 sultant, advisor, and auditor.

7 “(X) A list of all affiliates of the
8 pharmacy benefit manager.

9 “(XI) A summary document sub-
10 mitted in a standardized template de-
11 veloped by the Secretary that includes
12 such information described in sub-
13 clauses (I) through (X).

14 “(ii) WRITTEN EXPLANATION OF CON-
15 TRACTS OR AGREEMENTS WITH DRUG
16 MANUFACTURERS.—

17 “(I) IN GENERAL.—The phar-
18 macy benefit manager shall, not later
19 than 30 days after the finalization of
20 any contract or agreement between
21 such pharmacy benefit manager or an
22 affiliate of such pharmacy benefit
23 manager and a drug manufacturer (or
24 subsidiary, agent, or entity affiliated
25 with such drug manufacturer) that

1 makes rebates, discounts, payments,
2 or other financial incentives related to
3 one or more covered part D drugs or
4 other prescription drugs, as applica-
5 ble, of the manufacturer directly or
6 indirectly contingent upon coverage,
7 formulary placement, or utilization
8 management conditions on any other
9 covered part D drugs or other pre-
10 scription drugs, as applicable, submit
11 to the PDP sponsor a written expla-
12 nation of such contract or agreement.

13 “(II) REQUIREMENTS.—A writ-
14 ten explanation under subclause (I)
15 shall—

16 “(aa) include the manufac-
17 turer subject to the contract or
18 agreement, all covered part D
19 drugs and other prescription
20 drugs, as applicable, subject to
21 the contract or agreement and
22 the manufacturers of such drugs,
23 and a high-level description of
24 the terms of such contract or

1 agreement and how such terms
2 apply to such drugs; and

3 “(bb) be certified by the
4 Chief Executive Officer, Chief Fi-
5 nancial Officer, or General Coun-
6 sel of such pharmacy benefit
7 manager, or affiliate of such
8 pharmacy benefit manager, as
9 applicable, or an individual dele-
10 gated with the authority to sign
11 on behalf of one of these officers,
12 who reports directly to the offi-
13 cer.

14 “(III) DEFINITION OF OTHER
15 PRESCRIPTION DRUGS.—For purposes
16 of this clause, the term ‘other pre-
17 scription drugs’ means prescription
18 drugs covered as supplemental bene-
19 fits under this part or prescription
20 drugs paid outside of this part.

21 “(D) AUDIT RIGHTS.—

22 “(i) IN GENERAL.—Not less than once
23 a year, at the request of the PDP sponsor,
24 the pharmacy benefit manager shall allow
25 for an audit of the pharmacy benefit man-

1 ager to ensure compliance with all terms
2 and conditions under the written agree-
3 ment described in this paragraph and the
4 accuracy of information reported under
5 subparagraph (C).

6 “(ii) AUDITOR.—The PDP sponsor
7 shall have the right to select an auditor.
8 The pharmacy benefit manager shall not
9 impose any limitations on the selection of
10 such auditor.

11 “(iii) PROVISION OF INFORMATION.—
12 The pharmacy benefit manager shall make
13 available to such auditor all records, data,
14 contracts, and other information necessary
15 to confirm the accuracy of information
16 provided under subparagraph (C), subject
17 to reasonable restrictions on how such in-
18 formation must be reported to prevent re-
19 disclosure of such information.

20 “(iv) TIMING.—The pharmacy benefit
21 manager must provide information under
22 clause (iii) and other information, data,
23 and records relevant to the audit to such
24 auditor within 6 months of the initiation of
25 the audit and respond to requests for addi-

1 tional information from such auditor with-
2 in 30 days after the request for additional
3 information.

4 “(v) INFORMATION FROM AFFILI-
5 ATES.—The pharmacy benefit manager
6 shall be responsible for providing to such
7 auditor information required to be reported
8 under subparagraph (C) or under clause
9 (iii) of this subparagraph that is owned or
10 held by an affiliate of such pharmacy ben-
11 efit manager.

12 “(2) ENFORCEMENT.—

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

15 “(i) disgorge to the Secretary any
16 amounts disgorged to the PDP sponsor by
17 a pharmacy benefit manager under para-
18 graph (1)(A)(v);

19 “(ii) require, in a written agreement
20 with any pharmacy benefit manager acting
21 on behalf of such sponsor or affiliate of
22 such pharmacy benefit manager, that such
23 pharmacy benefit manager or affiliate re-
24 imburse the PDP sponsor for any civil
25 money penalty imposed on the PDP spon-

1 sor as a result of the failure of the phar-
2 macy benefit manager or affiliate to meet
3 the requirements of paragraph (1) that are
4 applicable to the pharmacy benefit man-
5 ager or affiliate under the agreement; and

6 “(iii) require, in a written agreement
7 with any such pharmacy benefit manager
8 acting on behalf of such sponsor or affil-
9 iate of such pharmacy benefit manager,
10 that such pharmacy benefit manager or af-
11 filiate be subject to punitive remedies for
12 breach of contract for failure to comply
13 with the requirements applicable under
14 paragraph (1).

15 “(B) REPORTING OF ALLEGED VIOLA-
16 TIONS.—The Secretary shall make available and
17 maintain a mechanism for manufacturers, PDP
18 sponsors, pharmacies, and other entities that
19 have contractual relationships with pharmacy
20 benefit managers or affiliates of such pharmacy
21 benefit managers to report, on a confidential
22 basis, alleged violations of paragraph (1)(A) or
23 subparagraph (C).

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

4 “(i) retaliate against an individual or
5 entity for reporting an alleged violation
6 under subparagraph (B); or

7 “(ii) coerce, intimidate, threaten, or
8 interfere with the ability of an individual
9 or entity to report any such alleged viola-
10 tions.

11 “(3) CERTIFICATION OF COMPLIANCE.—

12 “(A) IN GENERAL.—Each PDP sponsor
13 shall furnish to the Secretary (at a time and in
14 a manner specified by the Secretary) an annual
15 certification of compliance with this subsection,
16 as well as such information as the Secretary de-
17 termines necessary to carry out this subsection.

18 “(B) IMPLEMENTATION.—Notwithstanding
19 any other provision of law, the Secretary may
20 implement this paragraph by program instruc-
21 tion or otherwise.

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

24 “(A) prohibiting flat dispensing fees or re-
25 imbursement or payment for ingredient costs

1 (including customary, industry-standard dis-
2 counts directly related to drug acquisition that
3 are retained by pharmacies or wholesalers) to
4 entities that acquire or dispense prescription
5 drugs; or

6 “(B) modifying regulatory requirements or
7 sub-regulatory program instruction or guidance
8 related to pharmacy payment, reimbursement,
9 or dispensing fees.

10 “(5) STANDARD FORMATS.—

11 “(A) IN GENERAL.—Not later than June
12 1, 2028, the Secretary shall specify standard,
13 machine-readable formats for pharmacy benefit
14 managers to submit annual reports required
15 under paragraph (1)(C)(i).

16 “(B) IMPLEMENTATION.—Notwithstanding
17 any other provision of law, the Secretary may
18 implement this paragraph by program instruc-
19 tion or otherwise.

20 “(6) CONFIDENTIALITY.—

21 “(A) IN GENERAL.—Information disclosed
22 by a pharmacy benefit manager, an affiliate of
23 a pharmacy benefit manager, a PDP sponsor,
24 or a pharmacy under this subsection that is not
25 otherwise publicly available or available for pur-

1 chase shall not be disclosed by the Secretary or
2 a PDP sponsor receiving the information, ex-
3 cept that the Secretary may disclose the infor-
4 mation for the following purposes:

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

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

9 “(iii) To permit the Director of the
10 Congressional Budget Office to review the
11 information provided.

12 “(iv) To permit the Executive Direc-
13 tor of the Medicare Payment Advisory
14 Commission to review the information pro-
15 vided.

16 “(v) To the Attorney General for the
17 purposes of conducting oversight and en-
18 forcement under this title.

19 “(vi) To the Inspector General of the
20 Department of Health and Human Serv-
21 ices in accordance with its authorities
22 under the Inspector General Act of 1978
23 (section 406 of title 5, United States
24 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

1 any ownership structure to such pharmacy
2 benefit manager or PDP sponsor; or

3 “(ii) acts as a contractor, principal, or
4 agent to such pharmacy benefit manager
5 or PDP sponsor, insofar as such con-
6 tractor, principal, or agent performs any of
7 the functions described under subpara-
8 graph (C).

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

22 “(i) drug price, such as wholesale ac-
23 quisition cost or drug benchmark price
24 (such as average wholesale price);

1 “(ii) the amount of discounts, rebates,
2 fees, or other direct or indirect remunera-
3 tion with respect to covered part D drugs
4 dispensed to enrollees in a prescription
5 drug plan, except as permitted pursuant to
6 paragraph (1)(A)(ii);

7 “(iii) coverage or formulary placement
8 decisions or the volume or value of any re-
9 ferrals or business generated between the
10 parties to the arrangement; or

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

13 “(C) PHARMACY BENEFIT MANAGER.—The
14 term ‘pharmacy benefit manager’ means any
15 person or entity that, either directly or through
16 an intermediary, acts as a price negotiator or
17 group purchaser on behalf of a PDP sponsor or
18 prescription drug plan, or manages the pre-
19 scription drug benefits provided by such spon-
20 sor or plan, including the processing and pay-
21 ment of claims for prescription drugs, the per-
22 formance of drug utilization review, the proc-
23 essing of drug prior authorization requests, the
24 adjudication of appeals or grievances related to
25 the prescription drug benefit, contracting with

1 network pharmacies, controlling the cost of cov-
2 ered part D drugs, or the provision of related
3 services. Such term includes any person or enti-
4 ty that carries out one or more of the activities
5 described in the preceding sentence, irrespective
6 of whether such person or entity calls itself a
7 ‘pharmacy benefit manager’.”.

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

12 “(F) REQUIREMENTS RELATING TO PHAR-
13 MACY BENEFIT MANAGERS.—For plan years be-
14 ginning on or after January 1, 2029, section
15 1860D–12(h).”.

16 (3) NONAPPLICATION OF PAPERWORK REDUC-
17 TION ACT.—Chapter 35 of title 44, United States
18 Code, shall not apply to the implementation of this
19 subsection.

20 (4) FUNDING.—

21 (A) SECRETARY.—In addition to amounts
22 otherwise available, there is appropriated to the
23 Centers for Medicare & Medicaid Services Pro-
24 gram Management Account, out of any money
25 in the Treasury not otherwise appropriated,

1 \$113,000,000 for fiscal year 2026, to remain
2 available until expended, to carry out this sub-
3 section.

4 (B) OIG.—In addition to amounts other-
5 wise available, there is appropriated to the In-
6 specter General of the Department of Health
7 and Human Services, out of any money in the
8 Treasury not otherwise appropriated,
9 \$20,000,000 for fiscal year 2026, to remain
10 available until expended, to carry out this sub-
11 section.

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

14 (1) STUDY.—The Comptroller General of the
15 United States (in this subsection referred to as the
16 “Comptroller General”) shall conduct a study de-
17 scribing the use of compensation and payment struc-
18 tures related to a prescription drug’s price within
19 the retail prescription drug supply chain in part D
20 of title XVIII of the Social Security Act (42 U.S.C.
21 1395w–101 et seq.). Such study shall summarize in-
22 formation from Federal agencies and industry ex-
23 perts, to the extent available, with respect to the fol-
24 lowing:

1 (A) The type, magnitude, other features
2 (such as the pricing benchmarks used), and
3 prevalence of compensation and payment struc-
4 tures related to a prescription drug's price,
5 such as calculating fee amounts as a percentage
6 of a prescription drug's price, between inter-
7 mediaries in the prescription drug supply chain,
8 including—

- 9 (i) pharmacy benefit managers;
10 (ii) PDP sponsors offering prescrip-
11 tion drug plans and Medicare Advantage
12 organizations offering MA–PD plans;
13 (iii) drug wholesalers;
14 (iv) pharmacies;
15 (v) manufacturers;
16 (vi) pharmacy services administrative
17 organizations;
18 (vii) brokers, auditors, consultants,
19 and other entities that—

20 (I) advise PDP sponsors offering
21 prescription drug plans and Medicare
22 Advantage organizations offering MA–
23 PD plans regarding pharmacy bene-
24 fits; or

1 (II) review PDP sponsor and
2 Medicare Advantage organization con-
3 tracts with pharmacy benefit man-
4 agers; and

5 (viii) other service providers that con-
6 tract with any of the entities described in
7 clauses (i) through (vii) that may use
8 price-related compensation and payment
9 structures, such as rebate aggregators (or
10 other entities that negotiate or process
11 price concessions on behalf of pharmacy
12 benefit managers, plan sponsors, or phar-
13 macies).

14 (B) The primary business models and com-
15 pensation structures for each category of inter-
16 mediary described in subparagraph (A).

17 (C) Variation in price-related compensation
18 structures between affiliated entities (such as
19 entities with common ownership, either full or
20 partial, and subsidiary relationships) and unaf-
21 filiated entities.

22 (D) Potential conflicts of interest among
23 contracting entities related to the use of pre-
24 scription drug price-related compensation struc-
25 tures, such as the potential for fees or other

1 payments set as a percentage of a prescription
2 drug's price to advantage formulary selection,
3 distribution, or purchasing of prescription drugs
4 with higher prices.

5 (E) Notable differences, if any, in the use
6 and level of price-based compensation struc-
7 tures over time and between different market
8 segments, such as under part D of title XVIII
9 of the Social Security Act (42 U.S.C. 1395w-
10 101 et seq.) and the Medicaid program under
11 title XIX of such Act (42 U.S.C. 1396 et seq.).

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

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

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

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

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

14 (A) INITIAL REPORT.—Not later than the
15 first March 15 occurring after the date that is
16 2 years after the date on which the Secretary
17 makes the data available to the Commission, a
18 report regarding agreements with pharmacy
19 benefit managers with respect to prescription
20 drug plans and MA–PD plans. Such report
21 shall include, to the extent practicable—

22 (i) a description of trends and pat-
23 terns, including relevant averages, totals,
24 and other figures for the types of informa-
25 tion submitted;

1 (ii) an analysis of any differences in
2 agreements and their effects on plan en-
3 rollee out-of-pocket spending and average
4 pharmacy reimbursement, and other im-
5 pacts; and

6 (iii) any recommendations the Com-
7 mission determines appropriate.

8 (B) FINAL REPORT.—Not later than 2
9 years after the date on which the Commission
10 submits the initial report under subparagraph
11 (A), a report describing any changes with re-
12 spect to the information described in subpara-
13 graph (A) over time, together with any rec-
14 ommendations the Commission determines ap-
15 propriate.

16 (2) FUNDING.—In addition to amounts other-
17 wise available, there is appropriated to the Medicare
18 Payment Advisory Commission, out of any money in
19 the Treasury not otherwise appropriated,
20 \$1,000,000 for fiscal year 2026, to remain available
21 until expended, to carry out this subsection.

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

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

6 (1) in subparagraph (B)(viii)—

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

10 (B) in subclause (I)—

11 (i) by striking “subclause (II)” and
12 inserting “subclause (III)”; and

13 (ii) by striking “subclauses (II) and
14 (III)” and inserting “subclauses (III) and
15 (IV)”; and

16 (C) by inserting after subclause (I) the fol-
17 lowing:

18 “(II) Pursuant to subsection (a), subpara-
19 graphs (C) and (D) of section 406(a)(1) shall not
20 apply to a responsible plan fiduciary, notwith-
21 standing any failure to remit required amounts
22 under subparagraph (C)(i), if the following condi-
23 tions are met:

24 “(aa) The responsible plan fiduciary did
25 not know that the covered service provider
26 failed or would fail to make required remit-

1 tances and reasonably believed that the covered
2 service provider remitted such required
3 amounts.

4 “(bb) The responsible plan fiduciary, upon
5 discovering that the covered service provider
6 failed to remit the required amounts, requests
7 in writing that the covered service provider
8 remit such amounts.

9 “(cc) If the covered service provider fails
10 to comply with a written request described in
11 subclause (III) within 90 days of the request,
12 the responsible plan fiduciary notifies the Sec-
13 retary of the covered service provider’s failure,
14 in accordance with subclauses (III) and (IV).”;
15 and

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

17 “(C)(i)(I) For plan years beginning on or after
18 the date that is 30 months after the date of enact-
19 ment of this subparagraph (referred to in this clause
20 as the ‘effective date’), no contract or arrangement
21 or renewal or extension of a contract or arrange-
22 ment, entered into on or after the effective date, for
23 services between a covered plan and a covered serv-
24 ice provider, through a health insurance issuer offer-
25 ing group health insurance coverage, a third party

1 administrator, an entity providing pharmacy benefit
2 management services, or other entity, for pharmacy
3 benefit management services, is reasonable within
4 the meaning of this paragraph unless such entity
5 providing pharmacy benefit management services—

6 “(aa) remits 100 percent of rebates, fees,
7 alternative discounts, and other remuneration
8 received from any applicable entity that are re-
9 lated to utilization of drugs or drug spending
10 under such health plan or health insurance cov-
11 erage, to the group health plan or health insur-
12 ance issuer offering group health insurance cov-
13 erage; and

14 “(bb) does not enter into any contract for
15 pharmacy benefit management services on be-
16 half of such a plan or coverage, with an applica-
17 ble entity unless 100 percent of rebates, fees,
18 alternative discounts, and other remuneration
19 received under such contract that are related to
20 the utilization of drugs or drug spending under
21 such group health plan or health insurance cov-
22 erage are remitted to the group health plan or
23 health insurance issuer by the entity providing
24 pharmacy benefit management services.

1 “(II) Nothing in subclause (I) shall be con-
2 strued to affect the term of a contract or arrange-
3 ment, as in effect on the effective date (as described
4 in such subclause), except that such subclause shall
5 apply to any renewal or extension of such a contract
6 or arrangement entered into on or after such effec-
7 tive date, as so described.

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

10 “(I) the rebates, fees, alternative dis-
11 counts, and other remuneration under clause
12 (i)(I) shall be—

13 “(aa) remitted—

14 “(AA) on a quarterly basis, to
15 the group health plan or the group
16 health insurance issuer, not later than
17 90 days after the end of each quarter;
18 or

19 “(BB) in the case of an under-
20 payment in a remittance for a prior
21 quarter, as soon as practicable, but
22 not later than 90 days after notice of
23 the underpayment is first given;

1 “(bb) fully disclosed and enumerated
2 to the group health plan or health insur-
3 ance issuer; and

4 “(cc) returned to the covered service
5 provider for pharmacy benefit management
6 services on behalf of the group health plan
7 if any audit by a plan sponsor, issuer or a
8 third party designated by a plan sponsor,
9 indicates that the amounts received are in-
10 correct after such amounts have been paid
11 to the group health plan or health insur-
12 ance issuer;

13 “(II) the Secretary may establish proce-
14 dures for the remittance of rebates fees, alter-
15 native discounts, and other remuneration under
16 subclause (I)(aa) and the disclosure of rebates,
17 fees, alternative discounts, and other remunera-
18 tion under subclause (I)(bb); and

19 “(III) the records of such rebates, fees, al-
20 ternative discounts, and other remuneration
21 shall be available for audit by the plan sponsor,
22 issuer, or a third party designated by a plan
23 sponsor, not less than once per plan year.

24 “(iii) To ensure that an entity providing phar-
25 macy benefit management services is able to meet

1 the requirements of clause (ii)(I), a rebate
2 aggregator (or other purchasing entity designed to
3 aggregate rebates) and an applicable group pur-
4 chasing organization shall remit such rebates to the
5 entity providing pharmacy benefit management serv-
6 ices not later than 45 days after the end of each
7 quarter.

8 “(iv) A third-party administrator of a group
9 health plan, a health insurance issuer offering group
10 health insurance coverage, or a covered service pro-
11 vider for pharmacy benefit management services
12 under such health plan or health insurance coverage
13 shall make rebate contracts with rebate aggregators
14 or drug manufacturers available for audit by such
15 plan sponsor or designated third party, subject to
16 reasonable restrictions (as determined by the Sec-
17 retary) on confidentiality to prevent re-disclosure of
18 such contracts or use of such information in audits
19 for purposes unrelated to this section.

20 “(v) Audits carried out under clauses (ii)(III)
21 and (iv) shall be performed by an auditor selected by
22 the responsible plan fiduciary. Payment for such au-
23 dits shall not be made, whether directly or indirectly,
24 by the entity providing pharmacy benefit manage-
25 ment services.

1 “(vi) Nothing in this subparagraph shall be
2 construed to—

3 “(I) prohibit reasonable payments to enti-
4 ties offering pharmacy benefit management
5 services for bona fide services using a fee struc-
6 ture not described in this subparagraph, pro-
7 vided that such fees are transparent and quan-
8 tifiable to group health plans and health insur-
9 ance issuers;

10 “(II) require a third-party administrator of
11 a group health plan or covered service provider
12 for pharmacy benefit management services
13 under such health plan or health insurance cov-
14 erage to remit bona fide service fees to the
15 group health plan;

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

21 “(IV) modify the requirements for the cre-
22 ation, receipt, maintenance, or transmission of
23 protected health information under the privacy
24 regulations promulgated under the Health In-
25 surance Portability and Accountability Act of

1 1996 in part 160 and subparts A and E of part
 2 164 of title 45, Code of Federal Regulations (or
 3 successor regulations).

4 “(vii) For purposes of this subparagraph—

5 “(I) the terms ‘applicable entity’ and ‘ap-
 6 plicable group purchasing organization’ have
 7 the meanings given such terms in section
 8 726(e);

9 “(II) the terms ‘covered plan’, ‘covered
 10 service provider’, and ‘responsible plan fidu-
 11 ciary’ have the meanings given such terms in
 12 subparagraph (B); and

13 “(III) the terms ‘group health insurance
 14 coverage’, ‘health insurance coverage’, and
 15 ‘health insurance issuer’ have the meanings
 16 given such terms in section 733.”.

17 (b) RULE OF CONSTRUCTION.—Subclause (II)(aa) of
 18 section 408(b)(2)(B)(viii) of the Employee Retirement In-
 19 come Security Act of 1974 (29 U.S.C.
 20 1108(b)(2)(B)(viii)), as amended by subsection (a), shall
 21 not be construed to relieve or limit a responsible plan fidu-
 22 ciary from the duty to monitor the practices of any covered
 23 service provider that contracts with the applicable covered
 24 plan, including for the purposes of ensuring the reason-
 25 ableness of compensation. For purposes of this subsection,

1 the terms “covered plan”, “covered service provider”, and
 2 “responsible plan fiduciary” have the meanings given such
 3 terms in section 408(b)(2)(B)(ii) of the Employee Retirement
 4 Income Security Act of 1974 (29 U.S.C.
 5 1108(b)(2)(B)(ii)).

6 (c) CLARIFICATION OF COVERED SERVICE PRO-
 7 VIDER.—

8 (1) SERVICES.—

9 (A) IN GENERAL.—Section
 10 408(b)(2)(B)(ii)(I)(bb) of the Employee Retirement
 11 Income Security Act of 1974 (29 U.S.C.
 12 1108(b)(2)(B)(ii)(I)(bb)) is amended—

13 (i) in subitem (AA) by striking “Bro-
 14 kerage services,” and inserting “Services
 15 (including brokerage services),”; and

16 (ii) in subitem (BB)—

17 (I) by striking “Consulting,” and
 18 inserting “Other services,”; and

19 (II) by striking “related to the
 20 development or implementation of
 21 plan design” and all that follows
 22 through the period at the end and in-
 23 serting “including any of the fol-
 24 lowing: plan design, insurance or in-
 25 surance product selection (including

1 vision and dental), recordkeeping,
2 medical management, benefits admin-
3 istration selection (including vision
4 and dental), stop-loss insurance, phar-
5 macy benefit management services,
6 wellness design and management serv-
7 ices, transparency tools, group pur-
8 chasing organization agreements and
9 services, participation in and services
10 from preferred vendor panels, disease
11 management, compliance services, em-
12 ployee assistance programs, or third
13 party administration services, or con-
14 sulting services related to any such
15 services.”.

16 (B) SENSE OF CONGRESS.—It is the sense
17 of Congress that the amendment made by sub-
18 paragraph (A) clarifies the existing requirement
19 of covered service providers with respect to
20 services described in section
21 408(b)(2)(B)(ii)(I)(bb)(BB) of the Employee
22 Retirement Income Security Act of 1974 (29
23 U.S.C. 1108(b)(2)(B)(ii)(I)(bb)(BB)) that were
24 in effect since the application date described in
25 section 202(e) of the No Surprises Act (Public

1 Law 116–260; 29 U.S.C. 1108 note), and does
2 not impose any additional requirement under
3 section 408(b)(2)(B) of such Act.

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

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

11 (i) by striking “requirements of this
12 clause” and inserting “requirements of this
13 subparagraph”; and

14 (ii) by adding at the end the fol-
15 lowing: “For purposes of applying section
16 406(a)(1)(C) with respect to a transaction
17 described under this subparagraph or sub-
18 paragraph (C), a contract or arrangement
19 for services between a covered plan and an
20 entity providing services to the plan, in-
21 cluding a health insurance issuer providing
22 health insurance coverage in connection
23 with the covered plan, in which such entity
24 contracts, in connection with such plan,
25 with a service provider for pharmacy ben-

1 efit management services, shall be consid-
 2 ered an indirect furnishing of goods, serv-
 3 ices, or facilities between the covered plan
 4 and the service provider for pharmacy ben-
 5 efit management services acting as the
 6 party in interest.”.

7 (B) HEALTH INSURANCE ISSUER AND
 8 HEALTH INSURANCE COVERAGE DEFINED.—
 9 Section 408(b)(2)(B)(ii)(I)(aa) of such Act (29
 10 U.S.C. 1108(b)(2)(B)(ii)(I)(aa)) is amended by
 11 inserting before the period at the end “and the
 12 terms ‘health insurance coverage’ and ‘health
 13 insurance issuer’ have the meanings given such
 14 terms in section 733(b)”.

15 (C) TECHNICAL AMENDMENT.—Section
 16 408(b)(2)(B)(ii)(I)(aa) of the Employee Retire-
 17 ment Income Security Act of 1974 (29 U.S.C.
 18 1108(b)(2)(B)(ii)(I)(aa)) is amended by insert-
 19 ing “in” after “defined”.

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

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

1 “(i) QUALIFIED EXCHANGE ENROLLEES ELIGIBLE
2 TO ESTABLISH HEALTH SAVINGS ACCOUNTS.—

3 “(1) IN GENERAL.—For purposes of this sec-
4 tion, an individual who is a qualified Exchange en-
5 rollee for any month during a taxable year shall be
6 treated as an eligible individual for each of the
7 months in such taxable year and each taxable year
8 thereafter. Notwithstanding the previous sentence,
9 any individual who elects to make an advance pre-
10 mium payment under section 1412(c)(2)(C) of the
11 Patient Protection and Affordable Care Act with re-
12 spect to any month during a taxable year shall not
13 be treated as an eligible individual for such month
14 or any other month during such taxable year.

15 “(2) QUALIFIED EXCHANGE ENROLLEE.—For
16 purposes of this subsection, the term ‘qualified Ex-
17 change enrollee’ means, with respect to any month
18 during a taxable year, any individual if, as of the 1st
19 day of such month, such individual is enrolled in a
20 qualified health plan in the individual market
21 through an Exchange established under the Patient
22 Protection and Affordable Care Act that is—

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

1 “(B) in the case that, for any month dur-
2 ing the preceding taxable year, such individual
3 was enrolled in a qualified health plan in the in-
4 dividual market through such an Exchange (re-
5 ferred to in this paragraph as the ‘previous
6 plan’), such a qualified health plan for which
7 the monthly premium is lower than the monthly
8 premium that was in effect for the previous
9 plan.

10 “(3) APPLICATION OF MONTHLY LIMITATIONS
11 FOR CONTRIBUTIONS.—In the case of an individual
12 who is treated as an eligible individual under para-
13 graph (1), subsection (b)(2) shall be applied as if
14 each reference to ‘high deductible health plan’ were
15 a reference to ‘a qualified health plan in the indi-
16 vidual market that was enrolled in through an Ex-
17 change established under the Patient Protection and
18 Affordable Care Act’.

19 “(4) COORDINATION WITH CONTRIBUTIONS OF
20 PARTIAL ADVANCE PREMIUM TAX CREDIT.—The lim-
21 itation which would (but for this paragraph) apply
22 under subsection (b) for any taxable year to an indi-
23 vidual who is treated as an eligible individual under
24 paragraph (1) shall be reduced (but not below zero)
25 by the aggregate amount contributed to health sav-

1 ings accounts of such individual for such taxable
 2 year under section 1412(f) of the Patient Protection
 3 and Affordable Care Act (and such amount shall not
 4 be allowed as a deduction under subsection (a)).

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

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

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

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

20 (1) in subparagraph (B)(i), by inserting “, and,
 21 in the case of an individual who elects to make an
 22 advance premium payment under subparagraph (C),
 23 further reduce such premium by \$5” before the
 24 semicolon;

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

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

5 “(C) INDIVIDUAL OPTION TO PREPAY AN-
6 NUAL PREMIUM.—Beginning with plan years
7 beginning in 2026, in the case of an individual
8 with respect to whom an advance determination
9 has been made under section 1411 that such in-
10 dividual is eligible for a premium tax credit
11 under section 36B of the Internal Revenue
12 Code of 1986, if the premium assistance
13 amount under subsection (b)(2) of such section
14 is determined with respect to such individual in
15 accordance with subsection (b)(3)(A)(iii)(II) of
16 such section, such individual may elect to make
17 an advance premium payment to the issuer of
18 the qualified health plan in which such indi-
19 vidual is enrolled in an amount equal to \$5
20 multiplied by—

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

1 “(ii) in the case that the advance de-
2 termination of eligibility was made during
3 an open enrollment period other than the
4 annual open enrollment period for such
5 plan year, the number of months remain-
6 ing in such plan year.”.

7 (b) OPTION TO DIRECT PARTIAL ADVANCE PAY-
8 MENT OF PREMIUM TAX CREDIT INTO HSA.—Section
9 1412 of the Patient Protection and Affordable Care Act
10 (42 U.S.C. 18082) is amended—

11 (1) in subsection (c)(2)—

12 (A) in subparagraph (A), by striking
13 “The” and inserting “Subject to subsection (f),
14 the”; and

15 (B) in subparagraph (B), by inserting
16 “(including such a payment made in accordance
17 with subsection (f))” after “an advance pay-
18 ment”; and

19 (2) by adding at the end the following new sub-
20 section:

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

23 “(1) IN GENERAL.—Beginning with plan years
24 beginning in 2026, at the election of an eligible en-
25 rolled individual described in paragraph (2), the ad-

1 vance payment of the premium tax credit allowed
2 under section 36B of the Internal Revenue Code of
3 1986 shall be made as follows:

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

9 “(B) The Secretary of the Treasury shall
10 make advance payment of 50 percent of such
11 premium tax credit into a health savings ac-
12 count (as defined in section 223(d) of the Inter-
13 nal Revenue Code of 1986) of such individual
14 (as designated by such individual) on the same
15 basis provided for under subparagraph (A), but
16 only to the extent that the aggregate amount of
17 such payments does not exceed the limitation
18 under section 223(b) of such Code (determined
19 without regard to this subsection) which is ap-
20 plicable to such individual for the taxable year
21 in which such payments are made.

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

1 “(A) with respect to whom an advance de-
2 termination has been made under section 1411
3 that such individual is eligible for a premium
4 tax credit under section 36B of the Internal
5 Revenue Code of 1986;

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

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

13 **SEC. 9. REPORT.**

14 Not later than one year after the date of the enact-
15 ment of this Act, the Secretary of the Treasury and the
16 Secretary of Health and Human Services shall jointly sub-
17 mit to Congress a report on the implementation of sections
18 7 and 8 and any recommendations on expanding accessi-
19 bility of health savings accounts.

○