

Committee Print

**(Providing for reconciliation pursuant to H. Con. Res. 14, the
Concurrent Resolution on the Budget for Fiscal Year 2025)**

1 **TITLE IV—ENERGY AND**
2 **COMMERCE**

3 **Subtitle D—Health**

4 **PART 1—MEDICAID**

5 **Subpart A—Reducing Fraud and Improving**
6 **Enrollment Processes**

7 **SEC. 44101. MORATORIUM ON IMPLEMENTATION OF RULE**
8 **RELATING TO ELIGIBILITY AND ENROLL-**
9 **MENT IN MEDICARE SAVINGS PROGRAMS.**

10 The Secretary of Health and Human Services shall
11 not, during the period beginning on the date of the enact-
12 ment of this section and ending January 1, 2035, imple-
13 ment, administer, or enforce the provisions of the final
14 rule published by the Centers for Medicare & Medicaid
15 Services on September 21, 2023, and titled “Streamlining
16 Medicaid; Medicare Savings Program Eligibility Deter-
17 mination and Enrollment” (88 Fed. Reg. 65230).

1 **SEC. 44102. MORATORIUM ON IMPLEMENTATION OF RULE**
2 **RELATING TO ELIGIBILITY AND ENROLL-**
3 **MENT FOR MEDICAID, CHIP, AND THE BASIC**
4 **HEALTH PROGRAM.**

5 The Secretary of Health and Human Services shall
6 not, during the period beginning on the date of the enact-
7 ment of this section and ending January 1, 2035, imple-
8 ment, administer, or enforce the provisions of the final
9 rule published by the Centers for Medicare & Medicaid
10 Services on April 2, 2024, and titled “Medicaid Program;
11 Streamlining the Medicaid, Children’s Health Insurance
12 Program, and Basic Health Program Application, Eligi-
13 bility Determination, Enrollment, and Renewal Processes”
14 (89 Fed. Reg. 22780).

15 **SEC. 44103. ENSURING APPROPRIATE ADDRESS**
16 **VERIFICATION UNDER THE MEDICAID AND**
17 **CHIP PROGRAMS.**

18 (a) MEDICAID.—

19 (1) IN GENERAL.—Section 1902 of the Social
20 Security Act (42 U.S.C. 1396a) is amended—

21 (A) in subsection (a)—

22 (i) in paragraph (86), by striking
23 “and” at the end;

24 (ii) in paragraph (87), by striking the
25 period and inserting “; and”; and

1 (iii) by inserting after paragraph (87)
2 the following new paragraph:

3 “(88) provide—

4 “(A) beginning not later than January 1,
5 2027, in the case of 1 of the 50 States and the
6 District of Columbia, for a process to regularly
7 obtain address information for individuals en-
8 rolled under such plan (or a waiver of such
9 plan) in accordance with subsection (vv); and

10 “(B) beginning not later than October 1,
11 2029—

12 “(i) for the State to submit to the sys-
13 tem established by the Secretary under
14 subsection (uu), with respect to an indi-
15 vidual enrolled or seeking to enroll under
16 such plan, not less frequently than once
17 each month and during each determination
18 or redetermination of the eligibility of such
19 individual for medical assistance under
20 such plan (or waiver of such plan)—

21 “(I) the social security number of
22 such individual, if such individual has
23 a social security number and is re-
24 quired to provide such number to en-
25 roll under such plan (or waiver); and

1 “(II) such other information with
2 respect to such individual as deter-
3 mined necessary by the Secretary for
4 purposes of preventing individuals
5 from simultaneously being enrolled
6 under State plans (or waivers of such
7 plans) of multiple States;

8 “(ii) for the use of such system to
9 prevent such simultaneous enrollment; and

10 “(iii) in the case that such system in-
11 dicates that an individual enrolled or seek-
12 ing to enroll under such plan (or wavier of
13 such plan) is enrolled under a State plan
14 (or waiver of such a plan) of another
15 State, for the taking of appropriate action
16 (as determined by the Secretary) to iden-
17 tify whether such an individual resides in
18 the State and disenroll an individual from
19 the State plan of such State if such indi-
20 vidual does not reside in such State (unless
21 such individual meets such an exception as
22 the Secretary may specify).”; and

23 (B) by adding at the end the following new
24 subsections:

1 “(uu) PREVENTION OF ENROLLMENT UNDER MUL-
2 TIPLE STATE PLANS.—

3 “(1) IN GENERAL.—Not later than October 1,
4 2029, the Secretary shall establish a system to be
5 utilized by the Secretary and States to prevent an
6 individual from being simultaneously enrolled under
7 the State plans (or waivers of such plans) of mul-
8 tiple States. Such system shall—

9 “(A) provide for the receipt of information
10 submitted by a State under subsection
11 (a)(88)(B)(i); and

12 “(B) not less than once each month, notify
13 or transmit information to a State (or allow the
14 Secretary to notify or transmit information to a
15 State) regarding whether an individual enrolled
16 or seeking to enroll under the State plan of
17 such State (or waiver of such plan) is enrolled
18 under the State plan (or waiver of such plan)
19 of another State.

20 “(2) STANDARDS.—The Secretary shall estab-
21 lish such standards as determined necessary by the
22 Secretary to limit and protect information submitted
23 under such system and ensure the privacy of such
24 information, consistent with subsection (a)(7).

1 “(3) IMPLEMENTATION FUNDING.—There are
2 appropriated to the Secretary, out of amounts in the
3 Treasury not otherwise appropriated, in addition to
4 amounts otherwise available—

5 “(A) for fiscal year 2026, \$10,000,000 for
6 purposes of establishing the system required
7 under this subsection, to remain available until
8 expended; and

9 “(B) for fiscal year 2029, \$20,000,000 for
10 purposes of maintaining such system, to remain
11 available until expended.

12 “(vv) PROCESS TO OBTAIN ENROLLEE ADDRESS IN-
13 FORMATION.—

14 “(1) IN GENERAL.—For purposes of subsection
15 (a)(88)(A), a process to regularly obtain address in-
16 formation for individuals enrolled under a State plan
17 (or a waiver of such plan) shall obtain address infor-
18 mation from reliable data sources described in para-
19 graph (2) and take such actions as the Secretary
20 shall specify with respect to any changes to such ad-
21 dress based on such information.

22 “(2) RELIABLE DATA SOURCES DESCRIBED.—
23 For purposes of paragraph (1), the reliable data
24 sources described in this paragraph are the fol-
25 lowing:

1 “(A) Mail returned to the State by the
2 United States Postal Service with a forwarding
3 address.

4 “(B) The National Change of Address
5 Database maintained by the United States
6 Postal Service.

7 “(C) A managed care entity (as defined in
8 section 1932(a)(1)(B)) or prepaid inpatient
9 health plan or prepaid ambulatory health plan
10 (as such terms are defined in section
11 1903(m)(9)(D)) that has a contract under the
12 State plan if the address information is pro-
13 vided to such entity or plan directly from, or
14 verified by such entity or plan directly with,
15 such individual.

16 “(D) Other data sources as identified by
17 the State and approved by the Secretary.”.

18 (2) CONFORMING AMENDMENTS.—

19 (A) PARIS.—Section 1903(r)(3) of the
20 Social Security Act (42 U.S.C. 1396b(r)(3)) is
21 amended—

22 (i) by striking “In order” and insert-
23 ing “(A) In order”;

24 (ii) by striking “through the Public”
25 and inserting “through—

1 “(i) the Public”;

2 (iii) by striking the period at the end

3 and inserting “; and

4 “(ii) beginning October 1, 2029, the sys-
5 tem established by the Secretary under section
6 1902(uu).”; and

7 (iv) by adding at the end the following

8 new subparagraph:

9 “(B) Beginning October 1, 2029, the Secretary
10 may determine that a State is not required to have
11 in operation an eligibility determination system
12 which provides for data matching through the sys-
13 tem described in subparagraph (A)(i) to meet the re-
14 quirements of this paragraph.”.

15 (B) MANAGED CARE.—Section 1932 of the
16 Social Security Act (42 U.S.C. 1396u–2) is
17 amended by adding at the end the following
18 new subsection:

19 “(j) TRANSMISSION OF ADDRESS INFORMATION.—
20 Beginning January 1, 2027, each contract under a State
21 plan with a managed care entity (as defined in section
22 1932(a)(1)(B)) or with a prepaid inpatient health plan or
23 prepaid ambulatory health plan (as such terms are defined
24 in section 1903(m)(9)(D)), shall provide that such entity
25 or plan shall promptly transmit to the State any address

1 information for an individual enrolled with such entity or
2 plan that is provided to such entity or plan directly from,
3 or verified by such entity or plan directly with, such indi-
4 vidual.”.

5 (b) CHIP.—

6 (1) IN GENERAL.—Section 2107(e)(1) of the
7 Social Security Act (42 U.S.C. 1397gg(e)(1)) is
8 amended—

9 (A) by redesignating subparagraphs (H)
10 through (U) as subparagraphs (I) through (V),
11 respectively; and

12 (B) by inserting after subparagraph (G)
13 the following new subparagraph:

14 “(H) Section 1902(a)(88) (relating to ad-
15 dress information for enrollees and prevention
16 of simultaneous enrollments).”.

17 (2) MANAGED CARE.—Section 2103(f)(3) of the
18 Social Security Act (42 U.S.C. 1397cc(f)(3)) is
19 amended by striking “and (e)” and inserting “(e),
20 and (j)”.

1 **SEC. 44104. MODIFYING CERTAIN STATE REQUIREMENTS**
2 **FOR ENSURING DECEASED INDIVIDUALS DO**
3 **NOT REMAIN ENROLLED.**

4 Section 1902 of the Social Security Act (42 U.S.C.
5 1396a), as amended by section 44103, is further amend-
6 ed—

7 (1) in subsection (a)—

8 (A) in paragraph (87), by striking “; and”
9 and inserting a semicolon;

10 (B) in paragraph (88), by striking the pe-
11 riod at the end and inserting “; and”; and

12 (C) by inserting after paragraph (88) the
13 following new paragraph:

14 “(89) provide that the State shall comply with
15 the eligibility verification requirements under sub-
16 section (ww), except that this paragraph shall apply
17 only in the case of the 50 States and the District
18 of Columbia.”; and

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

21 “(ww) VERIFICATION OF CERTAIN ELIGIBILITY CRI-
22 TERIA.—

23 “(1) IN GENERAL.—For purposes of subsection
24 (a)(89), the eligibility verification requirements, be-
25 ginning January 1, 2028, are as follows:

1 “(A) QUARTERLY SCREENING TO VERIFY
2 ENROLLEE STATUS.—The State shall, not less
3 frequently than quarterly, review the Death
4 Master File (as such term is defined in section
5 203(d) of the Bipartisan Budget Act of 2013)
6 to determine whether any individuals enrolled
7 for medical assistance under the State plan (or
8 waiver of such plan) are deceased.

9 “(B) DISENROLLMENT UNDER STATE
10 PLAN.—If the State determines, based on infor-
11 mation obtained from the Death Master File,
12 that an individual enrolled for medical assist-
13 ance under the State plan (or waiver of such
14 plan) is deceased, the State shall—

15 “(i) treat such information as factual
16 information confirming the death of a ben-
17 eficiary for purposes of section 431.213(a)
18 of title 42, Code of Federal Regulations (or
19 any successor regulation);

20 “(ii) disenroll such individual from the
21 State plan (or waiver of such plan); and

22 “(iii) discontinue any payments for
23 medical assistance under this title made on
24 behalf of such individual (other than pay-
25 ments for any items or services furnished

1 to such individual prior to the death of
2 such individual).

3 “(C) REINSTATEMENT OF COVERAGE IN
4 THE EVENT OF ERROR.—If a State determines
5 that an individual was misidentified as deceased
6 based on information obtained from the Death
7 Master File and was erroneously disenrolled
8 from medical assistance under the State plan
9 (or waiver of such plan) based on such
10 misidentification, the State shall immediately
11 re-enroll such individual under the State plan
12 (or waiver of such plan), retroactive to the date
13 of such disenrollment.

14 “(2) RULE OF CONSTRUCTION.—Nothing under
15 this subsection shall be construed to preclude the
16 ability of a State to use other electronic data sources
17 to timely identify potentially deceased beneficiaries,
18 so long as the State is also in compliance with the
19 requirements of this subsection (and all other re-
20 quirements under this title relating to Medicaid eli-
21 gibility determination and redetermination).”.

22 **SEC. 44105. MEDICAID PROVIDER SCREENING REQUIRE-**
23 **MENTS.**

24 Section 1902(kk)(1) of the Social Security Act (42
25 U.S.C. 1396a(kk)(1)) is amended—

1 (1) by striking “The State” and inserting:

2 “(A) IN GENERAL.—The State”; and

3 (2) by adding at the end the following new sub-
4 paragraph:

5 “(B) ADDITIONAL PROVIDER SCREEN-
6 ING.—Beginning January 1, 2028, as part of
7 the enrollment (or reenrollment or revalidation
8 of enrollment) of a provider or supplier under
9 this title, and not less frequently than monthly
10 during the period that such provider or supplier
11 is so enrolled, the State conducts a check of any
12 database or similar system developed pursuant
13 to section 6401(b)(2) of the Patient Protection
14 and Affordable Care Act to determine whether
15 the Secretary has terminated the participation
16 of such provider or supplier under title XVIII,
17 or whether any other State has terminated the
18 participation of such provider or supplier under
19 such other State’s State plan under this title
20 (or waiver of the plan), or such other State’s
21 State child health plan under title XXI (or
22 waiver of the plan).”.

1 **SEC. 44106. ADDITIONAL MEDICAID PROVIDER SCREENING**
2 **REQUIREMENTS.**

3 Section 1902(kk)(1) of the Social Security Act (42
4 U.S.C. 1396a(kk)(1)), as amended by section 44105, is
5 further amended by adding at the end the following new
6 subparagraph:

7 “(C) PROVIDER SCREENING AGAINST
8 DEATH MASTER FILE.—Beginning January 1,
9 2028, as part of the enrollment (or reenroll-
10 ment or revalidation of enrollment) of a pro-
11 vider or supplier under this title, and not less
12 frequently than quarterly during the period that
13 such provider or supplier is so enrolled, the
14 State conducts a check of the Death Master
15 File (as such term is defined in section 203(d)
16 of the Bipartisan Budget Act of 2013) to deter-
17 mine whether such provider or supplier is de-
18 ceased.”.

19 **SEC. 44107. REMOVING GOOD FAITH WAIVER FOR PAYMENT**
20 **REDUCTION RELATED TO CERTAIN ERRO-**
21 **NEOUS EXCESS PAYMENTS UNDER MEDICAID.**

22 (a) IN GENERAL.—Section 1903(u)(1) of the Social
23 Security Act (42 U.S.C. 1396b(u)(1)) is amended—

24 (1) in subparagraph (B)—

1 (A) by striking “The Secretary” and in-
2 serting “(i) Subject to clause (ii), the Sec-
3 retary”; and

4 (B) by adding at the end the following new
5 clause:

6 “(ii) The amount waived under clause (i) for a
7 fiscal year may not exceed an amount equal to the
8 difference between—

9 “(I) the amount of the reduction required
10 under subparagraph (A) for such fiscal year
11 (without application of this subparagraph); and

12 “(II) the sum of the erroneous excess pay-
13 ments for medical assistance described in sub-
14 clauses (I) and (III) of subparagraph (D)(i)
15 made for such fiscal year.”;

16 (2) in subparagraph (C), by striking “he” in
17 each place it appears and inserting “the Secretary”
18 in each such place; and

19 (3) in subparagraph (D)(i)—

20 (A) in subclause (I), by striking “and” at
21 the end;

22 (B) in subclause (II), by striking the pe-
23 riod at the end and inserting “, and”; and

24 (C) by adding at the end the following new
25 subclause:

1 “(III) payments (other than payments de-
2 scribed in subclause (I)) for items and services fur-
3 nished to an eligible individual who is not eligible for
4 medical assistance under the State plan (or a waiver
5 of such plan) with respect to such items and serv-
6 ices.”.

7 (b) EFFECTIVE DATE.—The amendments made by
8 subsection (a) shall apply beginning with respect to fiscal
9 year 2030.

10 **SEC. 44108. INCREASING FREQUENCY OF ELIGIBILITY RE-**
11 **DETERMINATIONS FOR CERTAIN INDIVID-**
12 **UALS.**

13 Section 1902(e)(14) of the Social Security Act (42
14 U.S.C. 1396a(e)(14)) is amended by adding at the end
15 the following new subparagraph:

16 “(L) FREQUENCY OF ELIGIBILITY REDE-
17 TERMINATIONS FOR CERTAIN INDIVIDUALS.—
18 Beginning on October 1, 2027, in the case of
19 an individual enrolled under subsection
20 (a)(10)(A)(i)(VIII), a State shall redetermine
21 the eligibility of such individual for medical as-
22 sistance under the State plan of such State (or
23 a waiver of such plan) once every 6 months.”.

1 **SEC. 44109. REVISING HOME EQUITY LIMIT FOR DETER-**
2 **MINING ELIGIBILITY FOR LONG-TERM CARE**
3 **SERVICES UNDER THE MEDICAID PROGRAM.**

4 (a) REVISING HOME EQUITY LIMIT.—Section
5 1917(f)(1) of the Social Security Act (42 U.S.C.
6 1396p(f)(1)) is amended—

7 (1) in subparagraph (B)—

8 (A) by striking “A State” and inserting
9 “(i) A State”;

10 (B) in clause (i), as inserted by subpara-
11 graph (A)—

12 (i) by striking “‘\$500,000’” and in-
13 serting “the amount specified in subpara-
14 graph (A)”;

15 (ii) by inserting “, in the case of an
16 individual’s home that is located on a lot
17 that is zoned for agricultural use,” after
18 “apply subparagraph (A)”;

19 (C) by adding at the end the following new
20 clause:

21 “(ii) A State may elect, without regard to the
22 requirements of section 1902(a)(1) (relating to
23 statewideness) and section 1902(a)(10)(B) (relating
24 to comparability), to apply subparagraph (A), in the
25 case of an individual’s home that is not described in
26 clause (i), by substituting for the amount specified

1 in such subparagraph, an amount that exceeds such
2 amount, but does not exceed \$1,000,000.”; and

3 (2) in subparagraph (C)—

4 (A) by inserting “(other than the amount
5 specified in subparagraph (B)(ii) (relating to
6 certain non-agricultural homes))” after “speci-
7 fied in this paragraph”; and

8 (B) by adding at the end the following new
9 sentence: “In the case that application of the
10 preceding sentence would result in a dollar
11 amount (other than the amount specified in
12 subparagraph (B)(i) (relating to certain agricul-
13 tural homes)) exceeding \$1,000,000, such
14 amount shall be deemed to be equal to
15 \$1,000,000.”.

16 (b) CLARIFICATION.—Section 1902 of the Social Se-
17 curity Act (42 U.S.C. 1396a) is amended—

18 (1) in subsection (r)(2), by adding at the end
19 the following new subparagraph:

20 “(C) This paragraph shall not be construed as per-
21 mitting a State to determine the eligibility of an individual
22 for medical assistance with respect to nursing facility serv-
23 ices or other long-term care services without application
24 of the limit under section 1917(f)(1).”; and

25 (2) in subsection (e)(14)(D)(iv)—

1 (A) by striking “Subparagraphs” and in-
2 serting

3 “(I) IN GENERAL.—Subpara-
4 graphs”; and

5 (B) by adding at the end the following new
6 subclause:

7 “(II) APPLICATION OF HOME EQ-
8 UITY INTEREST LIMIT.—Section
9 1917(f) shall apply for purposes of de-
10 termining the eligibility of an indi-
11 vidual for medical assistance with re-
12 spect to nursing facility services or
13 other long-term care services.”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 subsection (a) shall apply beginning on January 1, 2028.

16 **SEC. 44110. PROHIBITING FEDERAL FINANCIAL PARTICIPA-**
17 **TION UNDER MEDICAID AND CHIP FOR INDI-**
18 **VIDUALS WITHOUT VERIFIED CITIZENSHIP,**
19 **NATIONALITY, OR SATISFACTORY IMMIGRA-**
20 **TION STATUS.**

21 (a) IN GENERAL.—

22 (1) MEDICAID.—Section 1903(i)(22) of the So-
23 cial Security Act (42 U.S.C. 1396b(i)(22)) is amend-
24 ed—

25 (A) by adding “and” at the end;

1 (B) by striking “to amounts” and inserting

2 “to—

3 “(A) amounts”; and

4 (C) by adding at the end the following new
5 subparagraph:

6 “(B) in the case that the State elects
7 under section 1902(a)(46)(C) to provide for
8 making medical assistance available to an indi-
9 vidual during—

10 “(i) the period in which the individual
11 is provided the reasonable opportunity to
12 present satisfactory documentary evidence
13 of citizenship or nationality under section
14 1902(ee)(2)(C) or subsection (x)(4);

15 “(ii) the 90-day period described in
16 section 1902(ee)(1)(B)(ii)(II); or

17 “(iii) the period in which the indi-
18 vidual is provided the reasonable oppor-
19 tunity to submit evidence indicating a sat-
20 isfactory immigration status under section
21 1137(d)(4),

22 amounts expended for such medical assistance,
23 unless the citizenship or nationality of such in-
24 dividual or the satisfactory immigration status

1 of such individual (as applicable) is verified by
2 the end of such period;”.

3 (2) CHIP.—Section 2107(e)(1)(N) of the So-
4 cial Security Act (42 U.S.C. 1397gg(e)(1)(N)) is
5 amended by striking “and (17)” and inserting
6 “(17), and (22)”.

7 (b) ELIMINATING STATE REQUIREMENT TO PROVIDE
8 MEDICAL ASSISTANCE DURING REASONABLE OPPOR-
9 TUNITY PERIOD.—

10 (1) DOCUMENTARY EVIDENCE OF CITIZENSHIP
11 OR NATIONALITY.—Section 1903(x)(4) of the Social
12 Security Act (42 U.S.C. 1396b(x)) is amended—

13 (A) by striking “under clauses (i) and (ii)
14 of section 1137(d)(4)(A)” and inserting “under
15 section 1137(d)(4)”;

16 (B) by inserting “, except that the State
17 shall not be required to make medical assist-
18 ance available to such individual during the pe-
19 riod in which such individual is provided such
20 reasonable opportunity if the State has not
21 elected the option under section
22 1902(a)(46)(C)” before the period at the end.

23 (2) SOCIAL SECURITY DATA MATCH.—Section
24 1902(ee) of the Social Security Act (42 U.S.C.
25 1396a(ee)) is amended—

1 (A) in paragraph (1)(B)(ii)—

2 (i) in subclause (II), by striking “(and
3 continues to provide the individual with
4 medical assistance during such 90-day pe-
5 riod)” and inserting “and, if the State has
6 elected the option under subsection
7 (a)(46)(C), continues to provide the indi-
8 vidual with medical assistance during such
9 90-day period”; and

10 (ii) in subclause (III), by inserting “,
11 or denies eligibility for medical assistance
12 under this title for such individual, as ap-
13 plicable” after “under this title”; and

14 (B) in paragraph (2)(C)—

15 (i) by striking “under clauses (i) and
16 (ii) of section 1137(d)(4)(A)” and insert-
17 ing “under section 1137(d)(4)”; and

18 (ii) by inserting “, except that the
19 State shall not be required to make med-
20 ical assistance available to such individual
21 during the period in which such individual
22 is provided such reasonable opportunity if
23 the State has not elected the option under
24 section 1902(a)(46)(C)” before the period
25 at the end.

1 (3) INDIVIDUALS WITH SATISFACTORY IMMI-
2 GRATION STATUS.—Section 1137(d)(4) of the Social
3 Security Act (42 U.S.C. 1320b–7(d)(4)) is amend-
4 ed—

5 (A) in subparagraph (A)(ii), by inserting
6 “(except that such prohibition on delay, denial,
7 reduction, or termination of eligibility for bene-
8 fits under the Medicaid program under title
9 XIX shall apply only if the State has elected
10 the option under section 1902(a)(46)(C))” after
11 “has been provided”; and

12 (B) in subparagraph (B)(ii), by inserting
13 “(except that such prohibition on delay, denial,
14 reduction, or termination of eligibility for bene-
15 fits under the Medicaid program under title
16 XIX shall apply only if the State has elected
17 the option under section 1902(a)(46)(C))” after
18 “status”.

19 (c) OPTION TO CONTINUE PROVIDING MEDICAL AS-
20 SISTANCE DURING REASONABLE OPPORTUNITY PE-
21 RIOD.—

22 (1) MEDICAID.—Section 1902(a)(46) of the So-
23 cial Security Act (42 U.S.C. 1396a(a)(46)) is
24 amended—

1 (A) in subparagraph (A), by striking
2 “and” at the end;

3 (B) in subparagraph (B)(ii), by adding
4 “and” at the end; and

5 (C) by inserting after subparagraph (B)(ii)
6 the following new subparagraph:

7 “(C) provide, at the option of the State, for
8 making medical assistance available—

9 “(i) to an individual described in subpara-
10 graph (B) during the period in which such indi-
11 vidual is provided the reasonable opportunity to
12 present satisfactory documentary evidence of
13 citizenship or nationality under subsection
14 (ee)(2)(C) or section 1903(x)(4), or during the
15 90-day period described in subsection
16 (ee)(1)(B)(ii)(II); or

17 “(ii) to an individual who is not a citizen
18 or national of the United States during the pe-
19 riod in which such individual is provided the
20 reasonable opportunity to submit evidence indi-
21 cating a satisfactory immigration status under
22 section 1137(d)(4);”.

23 (2) CHIP.—Section 2105(c)(9) of the Social
24 Security Act (42 U.S.C. 1397ee(c)(9)) is amended

1 by adding at the end the following new subpara-
2 graph:

3 “(C) OPTION TO CONTINUE PROVIDING
4 CHILD HEALTH ASSISTANCE DURING REASON-
5 ABLE OPPORTUNITY PERIOD.—Section
6 1902(a)(46)(C) shall apply to States under this
7 title in the same manner as it applies to a State
8 under title XIX.”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply beginning October 1, 2026.

11 **SEC. 44111. REDUCING EXPANSION FMAP FOR CERTAIN**
12 **STATES PROVIDING PAYMENTS FOR HEALTH**
13 **CARE FURNISHED TO CERTAIN INDIVIDUALS.**

14 Section 1905 of the Social Security Act (42 U.S.C.
15 1395d) is amended—

16 (1) in subsection (y)—

17 (A) in paragraph (1)(E), by inserting “(or,
18 for calendar quarters beginning on or after Oc-
19 tober 1, 2027, in the case such State is a speci-
20 fied State with respect to such calendar quar-
21 ter, 80 percent)” after “thereafter”; and

22 (B) in paragraph (2), by adding at the end
23 the following new subparagraph:

1 “(C) SPECIFIED STATE.—The term ‘speci-
2 fied State’ means, with respect to a quarter, a
3 State that—

4 “(i) provides any form of financial as-
5 sistance during such quarter, in whole or
6 in part, whether or not made under a
7 State plan (or waiver of such plan) under
8 this title or under another program estab-
9 lished by the State, and regardless of the
10 source of funding for such assistance, to or
11 on behalf of an alien who is not a qualified
12 alien or otherwise lawfully residing in the
13 United States for the purchasing of health
14 insurance coverage (as defined in section
15 2791(b)(1) of the Public Health Service
16 Act) for an alien who is not a qualified
17 alien or otherwise lawfully residing in the
18 United States; or

19 “(ii) provides any form of comprehen-
20 sive health benefits coverage during such
21 quarter, whether or not under a State plan
22 (or wavier of such plan) under this title or
23 under another program established by the
24 State, and regardless of the source of
25 funding for such coverage, to an alien who

1 is not a qualified alien or otherwise law-
2 fully residing in the United States.

3 “(D) IMMIGRATION TERMS.—

4 “(i) ALIEN.—The term ‘alien’ has the
5 meaning given such term in section 101(a)
6 of the Immigration and Nationality Act.

7 “(ii) QUALIFIED ALIEN.—The term
8 ‘qualified alien’ has the meaning given
9 such term in section 431 of the Personal
10 Responsibility and Work Opportunity Rec-
11 onciliation Act of 1996, except that—

12 “(I) the reference to ‘at the time
13 the alien applies for, receives, or at-
14 tempts to receive a Federal public
15 benefit’ in subsection (b) of such sec-
16 tion shall be treated as a reference to
17 ‘at the time the alien is provided com-
18 prehensive health benefits coverage
19 described in clause (ii) of section
20 1905(y)(C) of the Social Security Act
21 or is provided with financial assist-
22 ance described in clause (i) of such
23 section, as applicable’; and

24 “(II) the references to ‘(in the
25 opinion of the agency providing such

1 benefits)’ in subsection (c) of such
2 section shall be treated as references
3 to ‘(in the opinion of the State in
4 which such comprehensive health ben-
5 efits coverage or such financial assist-
6 ance is provided, as applicable)’.”; and

7 (2) in subsection (z)(2)—

8 (A) in subparagraph (A), by striking “for
9 such year” and inserting “for such quarter”;
10 and

11 (B) in subparagraph (B)(i)—

12 (i) in the matter preceding subclause
13 (I), by striking “for a year” and inserting
14 “for a calendar quarter in a year”; and

15 (ii) in subclause (II), by striking “for
16 the year” and inserting “for the quarter
17 for the State”.

18 **Subpart B—Preventing Wasteful Spending**

19 **SEC. 44121. MORATORIUM ON IMPLEMENTATION OF RULE**
20 **RELATING TO STAFFING STANDARDS FOR**
21 **LONG-TERM CARE FACILITIES UNDER THE**
22 **MEDICARE AND MEDICAID PROGRAMS.**

23 The Secretary of Health and Human Services shall
24 not, during the period beginning on the date of the enact-
25 ment of this section and ending January 1, 2035, imple-

1 ment, administer, or enforce the provisions of the final
2 rule published by the Centers for Medicare & Medicaid
3 Services on May 10, 2024, and titled “Medicare and Med-
4 icaid Programs; Minimum Staffing Standards for Long-
5 Term Care Facilities and Medicaid Institutional Payment
6 Transparency Reporting” (89 Fed. Reg. 40876).

7 **SEC. 44122. MODIFYING RETROACTIVE COVERAGE UNDER**
8 **THE MEDICAID AND CHIP PROGRAMS.**

9 (a) IN GENERAL.—Section 1902(a)(34) of the Social
10 Security Act (42 U.S.C. 1396a(a)(34)) is amended—

11 (1) by striking “him” and inserting “the indi-
12 vidual”;

13 (2) by striking “the third month” and inserting
14 “the month”;

15 (3) by striking “he” and inserting “the indi-
16 vidual”; and

17 (4) by striking “his” and inserting “the individ-
18 ual’s”.

19 (b) DEFINITION OF MEDICAL ASSISTANCE.—Section
20 1905(a) of the Social Security Act (42 U.S.C. 1396d(a))
21 is amended by striking “in or after the third month before
22 the month in which the recipient makes application for
23 assistance” and inserting “in or after the month before
24 the month in which the recipient makes application for
25 assistance”.

1 (c) CHIP.—Section 2102(b)(1)(B) of the Social Se-
2 curity Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

3 (1) in clause (iv), by striking “and” at the end;

4 (2) in clause (v), by striking the period and in-
5 serting “; and”; and

6 (3) by adding at the end the following new
7 clause:

8 “(vi) shall, in the case that the State
9 elects to provide child health or pregnancy-
10 related assistance to an individual for any
11 period prior to the month in which the in-
12 dividual made application for such assist-
13 ance (or application was made on behalf of
14 the individual), provide that such assist-
15 ance is not made available to such indi-
16 vidual for items and services included
17 under the State child health plan (or waiv-
18 er of such plan) that are furnished before
19 the month preceding the month in which
20 such individual made application (or appli-
21 cation was made on behalf of such indi-
22 vidual) for such assistance.”.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to medical assistance and child
25 health and pregnancy-related assistance with respect to in-

1 individuals whose eligibility for such medical assistance or
2 child health assistance is based on an application made
3 on or after October 1, 2026.

4 **SEC. 44123. ENSURING ACCURATE PAYMENTS TO PHAR-**
5 **MACIES UNDER MEDICAID.**

6 (a) IN GENERAL.—Section 1927(f) of the Social Se-
7 curity Act (42 U.S.C. 1396r–8(f)) is amended—

8 (1) in paragraph (1)(A)—

9 (A) by redesignating clause (ii) as clause
10 (iii); and

11 (B) by striking “and” after the semicolon
12 at the end of clause (i) and all that precedes it
13 through “(1)” and inserting the following:

14 “(1) DETERMINING PHARMACY ACTUAL ACQUI-
15 SITION COSTS.—The Secretary shall conduct a sur-
16 vey of retail community pharmacy drug prices and
17 applicable non-retail pharmacy drug prices to deter-
18 mine national average drug acquisition cost bench-
19 marks (as such term is defined by the Secretary) as
20 follows:

21 “(A) USE OF VENDOR.—The Secretary
22 may contract services for—

23 “(i) with respect to retail community
24 pharmacies, the determination of retail
25 survey prices of the national average drug

1 acquisition cost for covered outpatient
2 drugs that represent a nationwide average
3 of consumer purchase prices for such
4 drugs, net of all discounts, rebates, and
5 other price concessions (to the extent any
6 information with respect to such discounts,
7 rebates, and other price concessions is
8 available) based on a monthly survey of
9 such pharmacies;

10 “(ii) with respect to applicable non-re-
11 tail pharmacies—

12 “(I) the determination of survey
13 prices, separate from the survey prices
14 described in clause (i), of the non-re-
15 tail national average drug acquisition
16 cost for covered outpatient drugs that
17 represent a nationwide average of con-
18 sumer purchase prices for such drugs,
19 net of all discounts, rebates, and other
20 price concessions (to the extent any
21 information with respect to such dis-
22 counts, rebates, and other price con-
23 cessions is available) based on a
24 monthly survey of such pharmacies;
25 and

1 “(II) at the discretion of the Sec-
2 retary, for each type of applicable
3 non-retail pharmacy, the determina-
4 tion of survey prices, separate from
5 the survey prices described in clause
6 (i) or subclause (I) of this clause, of
7 the national average drug acquisition
8 cost for such type of pharmacy for
9 covered outpatient drugs that rep-
10 resent a nationwide average of con-
11 sumer purchase prices for such drugs,
12 net of all discounts, rebates, and other
13 price concessions (to the extent any
14 information with respect to such dis-
15 counts, rebates, and other price con-
16 cessions is available) based on a
17 monthly survey of such pharmacies;
18 and”;

19 (2) in subparagraph (B) of paragraph (1), by
20 striking “subparagraph (A)(ii)” and inserting “sub-
21 paragraph (A)(iii)”;

22 (3) in subparagraph (D) of paragraph (1), by
23 striking clauses (ii) and (iii) and inserting the fol-
24 lowing:

1 “(ii) The vendor must update the Sec-
2 retary no less often than monthly on the
3 survey prices for covered outpatient drugs.

4 “(iii) The vendor must differentiate,
5 in collecting and reporting survey data, for
6 all cost information collected, whether a
7 pharmacy is a retail community pharmacy
8 or an applicable non-retail pharmacy, in-
9 cluding whether such pharmacy is an affil-
10 iate (as defined in subsection (k)(14)),
11 and, in the case of an applicable non-retail
12 pharmacy, which type of applicable non-re-
13 tail pharmacy it is using the relevant phar-
14 macy type indicators included in the guid-
15 ance required by subsection (d)(2) of sec-
16 tion 44123 of the Act titled ‘An Act to
17 provide for reconciliation pursuant to title
18 II of H. Con. Res. 14’.”;

19 (4) by adding at the end of paragraph (1) the
20 following:

21 “(F) SURVEY REPORTING.—In order to
22 meet the requirement of section 1902(a)(54), a
23 State shall require that any retail community
24 pharmacy or applicable non-retail pharmacy in
25 the State that receives any payment, reimburse-

1 ment, administrative fee, discount, rebate, or
2 other price concession related to the dispensing
3 of covered outpatient drugs to individuals re-
4 ceiving benefits under this title, regardless of
5 whether such payment, reimbursement, admin-
6 istrative fee, discount, rebate, or other price
7 concession is received from the State or a man-
8 aged care entity or other specified entity (as
9 such terms are defined in section
10 1903(m)(9)(D)) directly or from a pharmacy
11 benefit manager or another entity that has a
12 contract with the State or a managed care enti-
13 ty or other specified entity (as so defined), shall
14 respond to surveys conducted under this para-
15 graph.

16 “(G) SURVEY INFORMATION.—Information
17 on national drug acquisition prices obtained
18 under this paragraph shall be made publicly
19 available in a form and manner to be deter-
20 mined by the Secretary and shall include at
21 least the following:

22 “(i) The monthly response rate to the
23 survey including a list of pharmacies not in
24 compliance with subparagraph (F).

1 “(ii) The sampling methodology and
2 number of pharmacies sampled monthly.

3 “(iii) Information on price concessions
4 to pharmacies, including discounts, re-
5 bates, and other price concessions, to the
6 extent that such information may be pub-
7 licly released and has been collected by the
8 Secretary as part of the survey.

9 “(H) PENALTIES.—

10 “(i) IN GENERAL.—Subject to clauses
11 (ii), (iii), and (iv), the Secretary shall en-
12 force the provisions of this paragraph with
13 respect to a pharmacy through the estab-
14 lishment of civil money penalties applicable
15 to a retail community pharmacy or an ap-
16 plicable non-retail pharmacy.

17 “(ii) BASIS FOR PENALTIES.—The
18 Secretary shall impose a civil money pen-
19 alty established under this subparagraph
20 on a retail community pharmacy or appli-
21 cable non-retail pharmacy if—

22 “(I) the retail pharmacy or appli-
23 cable non-retail pharmacy refuses or
24 otherwise fails to respond to a request
25 for information about prices in con-

1 nection with a survey under this sub-
2 section;

3 “(II) knowingly provides false in-
4 formation in response to such a sur-
5 vey; or

6 “(III) otherwise fails to comply
7 with the requirements established
8 under this paragraph.

9 “(iii) PARAMETERS FOR PEN-
10 ALTIES.—

11 “(I) IN GENERAL.—A civil money
12 penalty established under this sub-
13 paragraph may be assessed with re-
14 spect to each violation, and with re-
15 spect to each non-compliant retail
16 community pharmacy (including a
17 pharmacy that is part of a chain) or
18 non-compliant applicable non-retail
19 pharmacy (including a pharmacy that
20 is part of a chain), in an amount not
21 to exceed \$100,000 for each such vio-
22 lation.

23 “(II) CONSIDERATIONS.—In de-
24 termining the amount of a civil money
25 penalty imposed under this subpara-

1 graph, the Secretary may consider the
2 size, business structure, and type of
3 pharmacy involved, as well as the type
4 of violation and other relevant factors,
5 as determined appropriate by the Sec-
6 retary.

7 “(iv) RULE OF APPLICATION.—The
8 provisions of section 1128A (other than
9 subsections (a) and (b)) shall apply to a
10 civil money penalty under this subpara-
11 graph in the same manner as such provi-
12 sions apply to a civil money penalty or pro-
13 ceeding under section 1128A(a).

14 “(I) LIMITATION ON USE OF APPLICABLE
15 NON-RETAIL PHARMACY PRICING INFORMA-
16 TION.—No State shall use pricing information
17 reported by applicable non-retail pharmacies
18 under subparagraph (A)(ii) to develop or inform
19 payment methodologies for retail community
20 pharmacies.”;

21 (5) in paragraph (2)—

22 (A) in subparagraph (A), by inserting “,
23 including payment rates and methodologies for
24 determining ingredient cost reimbursement
25 under managed care entities or other specified

1 entities (as such terms are defined in section
2 1903(m)(9)(D)),” after “under this title”; and
3 (B) in subparagraph (B), by inserting
4 “and the basis for such dispensing fees” before
5 the semicolon;
6 (6) by redesignating paragraph (4) as para-
7 graph (5);
8 (7) by inserting after paragraph (3) the fol-
9 lowing new paragraph:

10 “(4) OVERSIGHT.—

11 “(A) IN GENERAL.—The Inspector General
12 of the Department of Health and Human Serv-
13 ices shall conduct periodic studies of the survey
14 data reported under this subsection, as appro-
15 priate, including with respect to substantial
16 variations in acquisition costs or other applica-
17 ble costs, as well as with respect to how internal
18 transfer prices and related party transactions
19 may influence the costs reported by pharmacies
20 that are affiliates (as defined in subsection
21 (k)(13)) or are owned by, controlled by, or re-
22 lated under a common ownership structure with
23 a wholesaler, distributor, or other entity that
24 acquires covered outpatient drugs relative to
25 costs reported by pharmacies not affiliated with

1 such entities. The Inspector General shall pro-
2 vide periodic updates to Congress on the results
3 of such studies, as appropriate, in a manner
4 that does not disclose trade secrets or other
5 proprietary information.

6 “(B) APPROPRIATION.—There is appro-
7 priated to the Inspector General of the Depart-
8 ment of Health and Human Services, out of
9 any money in the Treasury not otherwise ap-
10 propriated, \$5,000,000 for fiscal year 2026, to
11 remain available until expended, to carry out
12 this paragraph.”; and

13 (8) in paragraph (5), as so redesignated—

14 (A) by inserting “, and \$8,000,000 for
15 each of fiscal years 2026 through 2033,” after
16 “2010”; and

17 (B) by inserting “Funds appropriated
18 under this paragraph for each of fiscal years
19 2026 through 2033 shall remain available until
20 expended.” after the period.

21 (b) DEFINITIONS.—Section 1927(k) of the Social Se-
22 curity Act (42 U.S.C. 1396r–8(k)) is amended—

23 (1) in the matter preceding paragraph (1), by
24 striking “In the section” and inserting “In this sec-
25 tion”; and

1 (2) by adding at the end the following new
2 paragraphs:

3 “(12) APPLICABLE NON-RETAIL PHARMACY.—

4 The term ‘applicable non-retail pharmacy’ means a
5 pharmacy that is licensed as a pharmacy by the
6 State and that is not a retail community pharmacy,
7 including a pharmacy that dispenses prescription
8 medications to patients primarily through mail and
9 specialty pharmacies. Such term does not include
10 nursing home pharmacies, long-term care facility
11 pharmacies, hospital pharmacies, clinics, charitable
12 or not-for-profit pharmacies, government phar-
13 macies, or low dispensing pharmacies (as defined by
14 the Secretary).

15 “(13) AFFILIATE.—The term ‘affiliate’ means
16 any entity that is owned by, controlled by, or related
17 under a common ownership structure with a phar-
18 macy benefit manager or a managed care entity or
19 other specified entity (as such terms are defined in
20 section 1903(m)(9)(D)).”.

21 (c) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Subject to paragraph (2),
23 the amendments made by this section shall apply be-
24 ginning on the first day of the first quarter that be-

1 gins on or after the date that is 6 months after the
2 date of enactment of this section.

3 (2) DELAYED APPLICATION TO APPLICABLE
4 NON-RETAIL PHARMACIES.—The pharmacy survey
5 requirements established by the amendments to sec-
6 tion 1927(f) of the Social Security Act (42 U.S.C.
7 1396r–8(f)) made by this section shall apply to re-
8 tail community pharmacies beginning on the effec-
9 tive date described in paragraph (1), but shall not
10 apply to applicable non-retail pharmacies until the
11 first day of the first quarter that begins on or after
12 the date that is 18 months after the date of enact-
13 ment of this section.

14 (d) IDENTIFICATION OF APPLICABLE NON-RETAIL
15 PHARMACIES.—

16 (1) IN GENERAL.—Not later than January 1,
17 2027, the Secretary of Health and Human Services
18 shall, in consultation with stakeholders as appro-
19 priate, publish guidance specifying pharmacies that
20 meet the definition of applicable non-retail phar-
21 macies (as such term is defined in subsection
22 (k)(12) of section 1927 of the Social Security Act
23 (42 U.S.C. 1396r–8), as added by subsection (b)),
24 and that will be subject to the survey requirements

1 under subsection (f)(1) of such section, as amended
2 by subsection (a).

3 (2) INCLUSION OF PHARMACY TYPE INDICA-
4 TORS.—The guidance published under paragraph (1)
5 shall include pharmacy type indicators to distinguish
6 between different types of applicable non-retail phar-
7 macies, such as pharmacies that dispense prescrip-
8 tions primarily through the mail and pharmacies
9 that dispense prescriptions that require special han-
10 dling or distribution. An applicable non-retail phar-
11 macy may be identified through multiple pharmacy
12 type indicators.

13 (e) IMPLEMENTATION.—

14 (1) IN GENERAL.—Notwithstanding any other
15 provision of law, the Secretary of Health and
16 Human Services may implement the amendments
17 made by this section by program instruction or oth-
18 erwise.

19 (2) NONAPPLICATION OF ADMINISTRATIVE PRO-
20 CEDURE ACT.—Implementation of the amendments
21 made by this section shall be exempt from the re-
22 quirements of section 553 of title 5, United States
23 Code.

24 (f) NONAPPLICATION OF PAPERWORK REDUCTION
25 ACT.—Chapter 35 of title 44, United States Code, shall

1 not apply to any data collection undertaken by the Sec-
2 retary of Health and Human Services under section
3 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)),
4 as amended by this section.

5 **SEC. 44124. PREVENTING THE USE OF ABUSIVE SPREAD**
6 **PRICING IN MEDICAID.**

7 (a) IN GENERAL.—Section 1927 of the Social Secu-
8 rity Act (42 U.S.C. 1396r–8) is amended—

9 (1) in subsection (e), by adding at the end the
10 following new paragraph:

11 “(6) TRANSPARENT PRESCRIPTION DRUG PASS-
12 THROUGH PRICING REQUIRED.—

13 “(A) IN GENERAL.—A contract between
14 the State and a pharmacy benefit manager (re-
15 ferred to in this paragraph as a ‘PBM’), or a
16 contract between the State and a managed care
17 entity or other specified entity (as such terms
18 are defined in section 1903(m)(9)(D) and col-
19 lectively referred to in this paragraph as the
20 ‘entity’) that includes provisions making the en-
21 tity responsible for coverage of covered out-
22 patient drugs dispensed to individuals enrolled
23 with the entity, shall require that payment for
24 such drugs and related administrative services
25 (as applicable), including payments made by a

1 PBM on behalf of the State or entity, is based
2 on a transparent prescription drug pass-
3 through pricing model under which—

4 “(i) any payment made by the entity
5 or the PBM (as applicable) for such a
6 drug—

7 “(I) is limited to—

8 “(aa) ingredient cost; and

9 “(bb) a professional dis-
10 pensing fee that is not less than
11 the professional dispensing fee
12 that the State would pay if the
13 State were making the payment
14 directly in accordance with the
15 State plan;

16 “(II) is passed through in its en-
17 tirety (except as reduced under Fed-
18 eral or State laws and regulations in
19 response to instances of waste, fraud,
20 or abuse) by the entity or PBM to the
21 pharmacy or provider that dispenses
22 the drug; and

23 “(III) is made in a manner that
24 is consistent with sections 447.502,
25 447.512, 447.514, and 447.518 of

1 title 42, Code of Federal Regulations
2 (or any successor regulation) as if
3 such requirements applied directly to
4 the entity or the PBM, except that
5 any payment by the entity or the
6 PBM for the ingredient cost of such
7 drug purchased by a covered entity
8 (as defined in subsection (a)(5)(B))
9 may exceed the actual acquisition cost
10 (as defined in 447.502 of title 42,
11 Code of Federal Regulations, or any
12 successor regulation) for such drug
13 if—

14 “(aa) such drug was subject
15 to an agreement under section
16 340B of the Public Health Serv-
17 ice Act;

18 “(bb) such payment for the
19 ingredient cost of such drug does
20 not exceed the maximum pay-
21 ment that would have been made
22 by the entity or the PBM for the
23 ingredient cost of such drug if
24 such drug had not been pur-

1 chased by such covered entity;
2 and

3 “(cc) such covered entity re-
4 ports to the Secretary (in a form
5 and manner specified by the Sec-
6 retary), on an annual basis and
7 with respect to payments for the
8 ingredient costs of such drugs so
9 purchased by such covered entity
10 that are in excess of the actual
11 acquisition costs for such drugs,
12 the aggregate amount of such ex-
13 cess;

14 “(ii) payment to the entity or the
15 PBM (as applicable) for administrative
16 services performed by the entity or PBM is
17 limited to an administrative fee that re-
18 flects the fair market value (as defined by
19 the Secretary) of such services;

20 “(iii) the entity or the PBM (as appli-
21 cable) makes available to the State, and
22 the Secretary upon request in a form and
23 manner specified by the Secretary, all costs
24 and payments related to covered outpatient
25 drugs and accompanying administrative

1 services (as described in clause (ii)) in-
2 curred, received, or made by the entity or
3 the PBM, broken down (as specified by the
4 Secretary), to the extent such costs and
5 payments are attributable to an individual
6 covered outpatient drug, by each such
7 drug, including any ingredient costs, pro-
8 fessional dispensing fees, administrative
9 fees (as described in clause (ii)), post-sale
10 and post-invoice fees, discounts, or related
11 adjustments such as direct and indirect re-
12 muneration fees, and any and all other re-
13 muneration, as defined by the Secretary;
14 and

15 “(iv) any form of spread pricing
16 whereby any amount charged or claimed by
17 the entity or the PBM (as applicable) that
18 exceeds the amount paid to the pharmacies
19 or providers on behalf of the State or enti-
20 ty, including any post-sale or post-invoice
21 fees, discounts, or related adjustments
22 such as direct and indirect remuneration
23 fees or assessments, as defined by the Sec-
24 retary, (after allowing for an administra-
25 tive fee as described in clause (ii)) is not

1 allowable for purposes of claiming Federal
2 matching payments under this title.

3 “(B) PUBLICATION OF INFORMATION.—
4 The Secretary shall publish, not less frequently
5 than on an annual basis and in a manner that
6 does not disclose the identity of a particular
7 covered entity or organization, information re-
8 ceived by the Secretary pursuant to subpara-
9 graph (A)(iii)(III) that is broken out by State
10 and by each of the following categories of cov-
11 ered entity within each such State:

12 “(i) Covered entities described in sub-
13 paragraph (A) of section 340B(a)(4) of the
14 Public Health Service Act.

15 “(ii) Covered entities described in sub-
16 paragraphs (B) through (K) of such sec-
17 tion.

18 “(iii) Covered entities described in
19 subparagraph (L) of such section.

20 “(iv) Covered entities described in
21 subparagraph (M) of such section.

22 “(v) Covered entities described in sub-
23 paragraph (N) of such section.

24 “(vi) Covered entities described in
25 subparagraph (O) of such section.”; and

1 (2) in subsection (k), as previously amended by
2 this subtitle, by adding at the end the following new
3 paragraph:

4 “(14) PHARMACY BENEFIT MANAGER.—The
5 term ‘pharmacy benefit manager’ means any person
6 or entity that, either directly or through an inter-
7 mediary, acts as a price negotiator or group pur-
8 chaser on behalf of a State, managed care entity (as
9 defined in section 1903(m)(9)(D)), or other specified
10 entity (as so defined), or manages the prescription
11 drug benefits provided by a State, managed care en-
12 tity, or other specified entity, including the proc-
13 essing and payment of claims for prescription drugs,
14 the performance of drug utilization review, the proc-
15 essing of drug prior authorization requests, the man-
16 aging of appeals or grievances related to the pre-
17 scription drug benefits, contracting with pharmacies,
18 controlling the cost of covered outpatient drugs, or
19 the provision of services related thereto. Such term
20 includes any person or entity that acts as a price ne-
21 gotiator (with regard to payment amounts to phar-
22 macies and providers for a covered outpatient drug
23 or the net cost of the drug) or group purchaser on
24 behalf of a State, managed care entity, or other
25 specified entity or that carries out 1 or more of the

1 other activities described in the preceding sentence,
2 irrespective of whether such person or entity calls
3 itself a pharmacy benefit manager.”.

4 (b) CONFORMING AMENDMENTS.—Section 1903(m)
5 of such Act (42 U.S.C. 1396b(m)) is amended—

6 (1) in paragraph (2)(A)(xiii)—

7 (A) by striking “and (III)” and inserting
8 “(III)”;

9 (B) by inserting before the period at the
10 end the following: “, and (IV) if the contract in-
11 cludes provisions making the entity responsible
12 for coverage of covered outpatient drugs, the
13 entity shall comply with the requirements of
14 section 1927(e)(6)”;

15 (C) by moving the left margin 2 ems to the
16 left; and

17 (2) by adding at the end the following new
18 paragraph:

19 “(10) No payment shall be made under this
20 title to a State with respect to expenditures incurred
21 by the State for payment for services provided by an
22 other specified entity (as defined in paragraph
23 (9)(D)(iii)) unless such services are provided in ac-
24 cordance with a contract between the State and such

1 entity which satisfies the requirements of paragraph
2 (2)(A)(xiii).”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to contracts between States and
5 managed care entities, other specified entities, or phar-
6 macy benefit managers that have an effective date begin-
7 ning on or after the date that is 18 months after the date
8 of enactment of this section.

9 (d) IMPLEMENTATION.—

10 (1) IN GENERAL.—Notwithstanding any other
11 provision of law, the Secretary of Health and
12 Human Services may implement the amendments
13 made by this section by program instruction or oth-
14 erwise.

15 (2) NONAPPLICATION OF ADMINISTRATIVE PRO-
16 CEDURE ACT.—Implementation of the amendments
17 made by this section shall be exempt from the re-
18 quirements of section 553 of title 5, United States
19 Code.

20 (e) NONAPPLICATION OF PAPERWORK REDUCTION
21 ACT.—Chapter 35 of title 44, United States Code, shall
22 not apply to any data collection undertaken by the Sec-
23 retary of Health and Human Services under section
24 1927(e) of the Social Security Act (42 U.S.C. 1396r–
25 8(e)), as amended by this section.

1 **SEC. 44125. PROHIBITING FEDERAL MEDICAID AND CHIP**
2 **FUNDING FOR GENDER TRANSITION PROCE-**
3 **DURES FOR MINORS.**

4 (a) MEDICAID.—Section 1903(i) of the Social Secu-
5 rity Act (42 U.S.C. 1396b(i)) is amended—

6 (1) in paragraph (26), by striking “; or” and
7 inserting a semicolon;

8 (2) in paragraph (27), by striking the period at
9 the end and inserting “; or”;

10 (3) by inserting after paragraph (27) the fol-
11 lowing new paragraph:

12 “(28) with respect to any amount expended for
13 specified gender transition procedures (as defined in
14 section 1905(kk)) furnished to an individual under
15 18 years of age enrolled in a State plan (or waiver
16 of such plan).”; and

17 (4) in the flush left matter at the end, by strik-
18 ing “and (18),” and inserting “(18), and (28)”.

19 (b) CHIP.—Section 2107(e)(1)(N) of the Social Se-
20 curity Act (42 U.S.C. 1397gg(e)(1)(N)) is amended by
21 striking “and (17)” and inserting “(17), and (28)”.

22 (c) SPECIFIED GENDER TRANSITION PROCEDURES
23 DEFINED.—Section 1905 of the Social Security Act (42
24 U.S.C. 1396d) is amended by adding at the end the fol-
25 lowing new subsection:

1 “(kk) SPECIFIED GENDER TRANSITION PROCE-
2 DURES.—

3 “(1) IN GENERAL.—For purposes of section
4 1903(i)(28), except as provided in paragraph (2),
5 the term ‘specified gender transition procedure’
6 means, with respect to an individual, any of the fol-
7 lowing when performed for the purpose of inten-
8 tionally changing the body of such individual (in-
9 cluding by disrupting the body’s development, inhib-
10 iting its natural functions, or modifying its appear-
11 ance) to no longer correspond to the individual’s sex:

12 “(A) Performing any surgery, including—

13 “(i) castration;

14 “(ii) sterilization;

15 “(iii) orchiectomy;

16 “(iv) scrotoplasty;

17 “(v) vasectomy;

18 “(vi) tubal ligation;

19 “(vii) hysterectomy;

20 “(viii) oophorectomy;

21 “(ix) ovariectomy;

22 “(x) metoidioplasty;

23 “(xi) clitoroplasty;

- 1 “(xii) reconstruction of the fixed part
2 of the urethra with or without a
3 metoidioplasty or a phalloplasty;
4 “(xiii) penectomy;
5 “(xiv) phalloplasty;
6 “(xv) vaginoplasty;
7 “(xvi) vaginectomy;
8 “(xvii) vulvoplasty;
9 “(xviii) reduction thyrochondroplasty;
10 “(xix) chondrolaryngoplasty;
11 “(xx) mastectomy; and
12 “(xxi) any plastic, cosmetic, or aes-
13 thetic surgery that feminizes or
14 masculinizes the facial or other body fea-
15 tures of an individual.
- 16 “(B) Any placement of chest implants to
17 create feminine breasts or any placement of
18 erection or testicular prostheses.
- 19 “(C) Any placement of fat or artificial im-
20 plants in the gluteal region.
- 21 “(D) Administering, prescribing, or dis-
22 pensing to an individual medications, includ-
23 ing—
- 24 “(i) gonadotropin-releasing hormone
25 (GnRH) analogues or other puberty-block-

1 ing drugs to stop or delay normal puberty;
2 and

3 “(ii) testosterone, estrogen, or other
4 androgens to an individual at doses that
5 are supraphysiologic than would normally
6 be produced endogenously in a healthy in-
7 dividual of the same age and sex.

8 “(2) EXCEPTION.—Paragraph (1) shall not
9 apply to the following when furnished to an indi-
10 vidual by a health care provider with the consent of
11 such individual’s parent or legal guardian:

12 “(A) Puberty suppression or blocking pre-
13 scription drugs for the purpose of normalizing
14 puberty for an individual experiencing pre-
15 cocious puberty.

16 “(B) Medically necessary procedures or
17 treatments to correct for—

18 “(i) a medically verifiable disorder of
19 sex development, including—

20 “(I) 46,XX chromosomes with
21 virilization;

22 “(II) 46,XY chromosomes with
23 undervirilization; and

24 “(III) both ovarian and testicular
25 tissue;

1 “(ii) sex chromosome structure, sex
2 steroid hormone production, or sex hor-
3 mone action, if determined to be abnormal
4 by a physician through genetic or bio-
5 chemical testing;

6 “(iii) infection, disease, injury, or dis-
7 order caused or exacerbated by a previous
8 procedure described in paragraph (1), or a
9 physical disorder, physical injury, or phys-
10 ical illness that would, as certified by a
11 physician, place the individual in imminent
12 danger of death or impairment of a major
13 bodily function unless the procedure is per-
14 formed, not including procedures per-
15 formed for the alleviation of mental dis-
16 tress; or

17 “(iv) procedures to restore or recon-
18 struct the body of the individual in order
19 to correspond to the individual’s sex after
20 one or more previous procedures described
21 in paragraph (1), which may include the
22 removal of a pseudo phallus or breast aug-
23 mentation.

24 “(3) SEX.—For purposes of paragraph (1), the
25 term ‘sex’ means either male or female, as bio-

1 logically determined and defined in paragraphs (4)
2 and (5), respectively.

3 “(4) FEMALE.—For purposes of paragraph (3),
4 the term ‘female’ means an individual who naturally
5 has, had, will have, or would have, but for a develop-
6 mental or genetic anomaly or historical accident, the
7 reproductive system that at some point produces,
8 transports, and utilizes eggs for fertilization.

9 “(5) MALE.—For purposes of paragraph (3),
10 the term ‘male’ means an individual who naturally
11 has, had, will have, or would have, but for a develop-
12 mental or genetic anomaly or historical accident, the
13 reproductive system that at some point produces,
14 transports, and utilizes sperm for fertilization.”.

15 **SEC. 44126. FEDERAL PAYMENTS TO PROHIBITED ENTI-**
16 **TIES.**

17 (a) IN GENERAL.—No Federal funds that are consid-
18 ered direct spending and provided to carry out a State
19 plan under title XIX of the Social Security Act or a waiver
20 of such a plan shall be used to make payments to a prohib-
21 ited entity for items and services furnished during the 10-
22 year period beginning on the date of the enactment of this
23 Act, including any payments made directly to the prohib-
24 ited entity or under a contract or other arrangement be-
25 tween a State and a covered organization.

1 (b) DEFINITIONS.—In this section:

2 (1) PROHIBITED ENTITY.—The term “prohib-
3 ited entity” means an entity, including its affiliates,
4 subsidiaries, successors, and clinics—

5 (A) that, as of the date of enactment of
6 this Act—

7 (i) is an organization described in sec-
8 tion 501(c)(3) of the Internal Revenue
9 Code of 1986 and exempt from tax under
10 section 501(a) of such Code;

11 (ii) is an essential community provider
12 described in section 156.235 of title 45,
13 Code of Federal Regulations (as in effect
14 on the date of enactment of this Act), that
15 is primarily engaged in family planning
16 services, reproductive health, and related
17 medical care; and

18 (iii) provides for abortions, other than
19 an abortion—

20 (I) if the pregnancy is the result
21 of an act of rape or incest; or

22 (II) in the case where a woman
23 suffers from a physical disorder, phys-
24 ical injury, or physical illness, includ-
25 ing a life-endangering physical condi-

1 tion caused by or arising from the
2 pregnancy itself, that would, as cer-
3 tified by a physician, place the woman
4 in danger of death unless an abortion
5 is performed; and

6 (B) for which the total amount of Federal
7 and State expenditures under the Medicaid pro-
8 gram under title XIX of the Social Security Act
9 in fiscal year 2024 made directly, or by a cov-
10 ered organization, to the entity or to any affili-
11 ates, subsidiaries, successors, or clinics of the
12 entity, or made to the entity or to any affiliates,
13 subsidiaries, successors, or clinics of the entity
14 as part of a nationwide health care provider
15 network, exceeded \$1,000,000.

16 (2) DIRECT SPENDING.—The term “direct
17 spending” has the meaning given that term under
18 section 250(c) of the Balanced Budget and Emer-
19 gency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

20 (3) COVERED ORGANIZATION.—The term “cov-
21 ered organization” means a managed care entity (as
22 defined in section 1932(a)(1)(B) of the Social Secu-
23 rity Act (42 U.S.C. 1396u–2(a)(1)(B))) or a prepaid
24 inpatient health plan or prepaid ambulatory health
25 plan (as such terms are defined in section

1 1903(m)(9)(D) of such Act (42 U.S.C.
2 1396b(m)(9)(D))).

3 (4) STATE.—The term “State” has the mean-
4 ing given such term in section 1101 of the Social Se-
5 curity Act (42 U.S.C. 1301).

6 **Subpart C—Stopping Abusive Financing Practices**

7 **SEC. 44131. SUNSETTING ELIGIBILITY FOR INCREASED**
8 **FMAP FOR NEW EXPANSION STATES.**

9 Section 1905(ii)(3) of the Social Security Act (42
10 U.S.C. 1396d(ii)(3)) is amended—

11 (1) by striking “which has not” and inserting
12 the following: “which—

13 “(A) has not”;

14 (2) in subparagraph (A), as so inserted, by
15 striking the period at the end and inserting “; and”;
16 and

17 (3) by adding at the end the following new sub-
18 paragraph:

19 “(B) begins to expend amounts for all such
20 individuals prior to January 1, 2026.”.

21 **SEC. 44132. MORATORIUM ON NEW OR INCREASED PRO-**
22 **VIDER TAXES.**

23 Section 1903(w)(1)(A)(iii) of the Social Security Act
24 (42 U.S.C. 1396b(w)(1)(A)(iii)) is amended—

25 (1) by striking “or” at the end;

1 (2) by striking “if there” and inserting “if—

2 “(I) there”; and

3 (3) by adding at the end the following new sub-

4 clauses:

5 “(II) the tax is first imposed by the State

6 (or by a unit of local government in the State)

7 on or after the date of the enactment of this

8 subclause (other than such a tax for which the

9 legislation or regulations providing for the im-

10 position of such tax were enacted or adopted

11 prior to such date of enactment); or

12 “(III) on or after the date of the enact-

13 ment of this subclause, the State (or unit of

14 local government) increases the amount or rate

15 of tax imposed with respect to a class of health

16 care items or services (or with respect to a type

17 of provider or activity within such a class), or

18 increases the base of the tax such that the tax

19 is imposed with respect to a class of items or

20 services (or with respect to a type of provider

21 or activity within such a class) to which the tax

22 did not previously apply, but only to the extent

23 that such revenues are attributable to such in-

24 crease and only if such increase was not pro-

1 vided for in legislation or regulations enacted or
2 adopted prior to such date of enactment; or”.

3 **SEC. 44133. REVISING THE PAYMENT LIMIT FOR CERTAIN**
4 **STATE DIRECTED PAYMENTS.**

5 (a) IN GENERAL.—Subject to subsection (b), the Sec-
6 retary of Health and Human Services shall revise section
7 438.6(c)(2)(iii) of title 42, Code of Federal Regulations
8 (or a successor regulation) such that, with respect to a
9 payment described in such section made for a service fur-
10 nished during a rating period beginning on or after the
11 date of the enactment of this Act, the total payment rate
12 for such service is limited to 100 percent of the specified
13 total published Medicare payment rate.

14 (b) GRANDFATHERING CERTAIN PAYMENTS.—In the
15 case of a payment described in section 438.6(c)(2)(iii) of
16 title 42, Code of Federal Regulations (or a successor regu-
17 lation) for which written prior approval was made before
18 the date of the enactment of this Act for the rating period
19 occurring as of such date of enactment, the revisions de-
20 scribed in subsection (a) shall not apply to such payment
21 for such rating period and for any subsequent rating pe-
22 riod if the amount of such payment does not exceed the
23 amount of such payment so approved.

24 (c) DEFINITIONS.—In this section:

1 (1) RATING PERIOD.—The term “rating pe-
2 riod” has the meaning given such term in section
3 438.2 of title 42, Code of Federal Regulations (or a
4 successor regulation).

5 (2) TOTAL PUBLISHED MEDICARE PAYMENT
6 RATE.—The term “total published Medicare pay-
7 ment rate” means amounts calculated as payment
8 for specific services that have been developed under
9 part A or part B of title XVIII of the Social Secu-
10 rity Act (42 U.S.C. 1395 et seq.).

11 (3) WRITTEN PRIOR APPROVAL.—The term
12 “written prior approval” has the meaning given such
13 term in section 438.6(c)(2)(i) of title 42, Code of
14 Federal Regulations (or a successor regulation).

15 (d) FUNDING.—There are appropriated out of any
16 monies in the Treasury not otherwise appropriated
17 \$7,000,000 for each of fiscal years 2026 through 2033
18 for purposes of carrying out this section.

19 **SEC. 44134. REQUIREMENTS REGARDING WAIVER OF UNI-**
20 **FORM TAX REQUIREMENT FOR MEDICAID**
21 **PROVIDER TAX.**

22 (a) IN GENERAL.—Section 1903(w) of the Social Se-
23 curity Act (42 U.S.C. 1396b(w)) is amended—

24 (1) in paragraph (3)(E), by inserting after
25 clause (ii)(II) the following new clause:

1 “(iii) For purposes of clause (ii)(I), a tax is not con-
2 sidered to be generally redistributive if any of the following
3 conditions apply:

4 “(I) Within a permissible class, the tax rate im-
5 posed on any taxpayer or tax rate group (as defined
6 in paragraph (7)(J)) explicitly defined by its rel-
7 atively lower volume or percentage of Medicaid tax-
8 able units (as defined in paragraph (7)(H)) is lower
9 than the tax rate imposed on any other taxpayer or
10 tax rate group explicitly defined by its relatively
11 higher volume or percentage of Medicaid taxable
12 units.

13 “(II) Within a permissible class, the tax rate
14 imposed on any taxpayer or tax rate group (as so
15 defined) based upon its Medicaid taxable units (as
16 so defined) is higher than the tax rate imposed on
17 any taxpayer or tax rate group based upon its non-
18 Medicaid taxable unit (as defined in paragraph
19 (7)(I)).

20 “(III) The tax excludes or imposes a lower tax
21 rate on a taxpayer or tax rate group (as so defined)
22 based on or defined by any description that results
23 in the same effect as described in subclause (I) or
24 (II) for a taxpayer or tax rate group. Characteristics

1 that may indicate such type of exclusion include the
2 use of terminology to establish a tax rate group—

3 “(aa) based on payments or expenditures
4 made under the program under this title with-
5 out mentioning the term ‘Medicaid’ (or any
6 similar term) to accomplish the same effect as
7 described in subclause (I) or (II); or

8 “(bb) that closely approximates a taxpayer
9 or tax rate group under the program under this
10 title, to the same effect as described in sub-
11 clause (I) or (II).”; and

12 (2) in paragraph (7), by adding at the end the
13 following new subparagraphs:

14 “(H) The term ‘Medicaid taxable unit’ means a
15 unit that is being taxed within a health care related
16 tax that is applicable to the program under this title.
17 Such term includes a unit that is used as the basis
18 for—

19 “(i) payment under the program under this
20 title (such as Medicaid bed days);

21 “(ii) Medicaid revenue;

22 “(iii) costs associated with the program
23 under this title (such as Medicaid charges,
24 claims, or expenditures); and

1 “(iv) other units associated with the pro-
2 gram under this title, as determined by the Sec-
3 retary.

4 “(I) The term ‘non-Medicaid taxable unit’
5 means a unit that is being taxed within a health
6 care related tax that is not applicable to the pro-
7 gram under this title. Such term includes a unit that
8 is used as the basis for—

9 “(i) payment by non-Medicaid payers (such
10 as non-Medicaid bed days);

11 “(ii) non-Medicaid revenue;

12 “(iii) costs that are not associated with the
13 program under this title (such as non-Medicaid
14 charges, non-Medicaid claims, or non-Medicaid
15 expenditures); and

16 “(iv) other units not associated with the
17 program under this title, as determined by the
18 Secretary.

19 “(J) The term ‘tax rate group’ means a group
20 of entities contained within a permissible class of a
21 health care related tax that are taxed at the same
22 rate.”.

23 (b) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect upon the date of enactment
25 of this Act, subject to any applicable transition period de-

1 terminated appropriate by the Secretary of Health and
2 Human Services, not to exceed 3 fiscal years.

3 **SEC. 44135. REQUIRING BUDGET NEUTRALITY FOR MED-**
4 **ICAID DEMONSTRATION PROJECTS UNDER**
5 **SECTION 1115.**

6 Section 1115 of the Social Security Act (42 U.S.C.
7 1315) is amended by adding at the end the following new
8 subsection:

9 “(g) REQUIREMENT OF BUDGET NEUTRALITY FOR
10 MEDICAID DEMONSTRATION PROJECTS.—

11 “(1) IN GENERAL.—Beginning on the date of
12 the enactment of this subsection, the Secretary may
13 not approve an application for (or renewal or
14 amendment of) an experimental, pilot, or demonstra-
15 tion project undertaken under subsection (a) to pro-
16 mote the objectives of title XIX in a State (in this
17 subsection referred to as a ‘Medicaid demonstration
18 project’) unless the Secretary certifies that such
19 project is not expected to result in an increase in the
20 amount of Federal expenditures compared to the
21 amount that such expenditures would otherwise be
22 in the absence of such project.

23 “(2) TREATMENT OF SAVINGS.—In the event
24 that Federal expenditures with respect to a State
25 under a Medicaid demonstration project are, during

1 an approval period for such project, less than the
2 amount of such expenditures that would have other-
3 wise been made in the absence of such project, the
4 Secretary shall specify the methodology to be used
5 with respect to any subsequent approval period for
6 such project for purposes of taking the difference be-
7 tween such expenditures into account.”.

8 **Subpart D—Increasing Personal Accountability**

9 **SEC. 44141. REQUIREMENT FOR STATES TO ESTABLISH**
10 **MEDICAID COMMUNITY ENGAGEMENT RE-**
11 **QUIREMENTS FOR CERTAIN INDIVIDUALS.**

12 (a) IN GENERAL.—Section 1902 of the Social Secu-
13 rity Act (42 U.S.C. 1396a), as amended by sections 44103
14 and 44104, is further amended by adding at the end the
15 following new subsection:

16 “(xx) COMMUNITY ENGAGEMENT REQUIREMENT FOR
17 APPLICABLE INDIVIDUALS.—

18 “(1) IN GENERAL.—Beginning January 1,
19 2029, subject to the succeeding provisions of this
20 subsection, a State shall provide, as a condition of
21 eligibility for medical assistance for an applicable in-
22 dividual, that such individual is required to dem-
23 onstrate community engagement under paragraph
24 (2)—

1 “(A) in the case of an applicable individual
2 who has filed an application for medical assist-
3 ance under a State plan (or a waiver of such
4 plan) under this title, for 1 or more (as speci-
5 fied by the State) consecutive months imme-
6 diately preceding the month during which such
7 individual applies for such medical assistance;
8 and

9 “(B) in the case of an applicable individual
10 enrolled and receiving medical assistance under
11 a State plan (or under a waiver of such plan)
12 under this title, for 1 or more (as specified by
13 the State) months, whether or not consecu-
14 tive—

15 “(i) during the period between such
16 individual’s most recent determination (or
17 redetermination, as applicable) of eligibility
18 and such individual’s next regularly sched-
19 uled redetermination of eligibility (as
20 verified by the State as part of such regu-
21 larly scheduled redetermination of eligi-
22 bility); or

23 “(ii) in the case of a State that has
24 elected under paragraph (4) to conduct
25 more frequent verifications of compliance

1 with the requirement to demonstrate com-
2 munity engagement, during the period be-
3 tween the most recent and next such
4 verification with respect to such individual.

5 “(2) COMMUNITY ENGAGEMENT COMPLIANCE
6 DESCRIBED.—Subject to paragraph (3), an applica-
7 ble individual demonstrates community engagement
8 under this paragraph for a month if such individual
9 meets 1 or more of the following conditions with re-
10 spect to such month, as determined in accordance
11 with criteria established by the Secretary through
12 regulation:

13 “(A) The individual works not less than 80
14 hours.

15 “(B) The individual completes not less
16 than 80 hours of community service.

17 “(C) The individual participates in a work
18 program for not less than 80 hours.

19 “(D) The individual is enrolled in an edu-
20 cational program at least half-time.

21 “(E) The individual engages in any com-
22 bination of the activities described in subpara-
23 graphs (A) through (D), for a total of not less
24 than 80 hours.

1 “(F) The individual has a monthly income
2 that is not less than the applicable minimum
3 wage requirement under section 6 of the Fair
4 Labor Standards Act of 1938, multiplied by 80
5 hours.

6 “(3) EXCEPTIONS.—

7 “(A) MANDATORY EXCEPTION FOR CER-
8 TAIN INDIVIDUALS.—The State shall deem an
9 applicable individual to have demonstrated com-
10 munity engagement under paragraph (2) for a
11 month if—

12 “(i) for part or all of such month, the
13 individual—

14 “(I) was a specified excluded in-
15 dividual (as defined in paragraph
16 (9)(A)(ii)); or

17 “(II) was—

18 “(aa) under the age of 19;

19 “(bb) pregnant or entitled to
20 postpartum medical assistance
21 under paragraph (5) or (16) of
22 subsection (e);

23 “(cc) entitled to, or enrolled
24 for, benefits under part A of title

1 XVIII, or enrolled for benefits
2 under part B of title XVIII; or

3 “(dd) described in any of
4 subclauses (I) through (VII) of
5 subsection (a)(10)(A)(i); or

6 “(ii) at any point during the 3-month
7 period ending on the first day of such
8 month, the individual was an inmate of a
9 public institution.

10 “(B) OPTIONAL EXCEPTION FOR SHORT-
11 TERM HARDSHIP EVENTS.—

12 “(i) IN GENERAL.—The State plan (or
13 waiver of such plan) may provide, in the
14 case of an applicable individual who experi-
15 ences a short-term hardship event during a
16 month, that the State shall, upon the re-
17 quest of such individual under procedures
18 established by the State (in accordance
19 with standards specified by the Secretary),
20 deem such individual to have demonstrated
21 community engagement under paragraph
22 (2) for such month.

23 “(ii) SHORT-TERM HARDSHIP EVENT
24 DEFINED.—For purposes of this subpara-
25 graph, an applicable individual experiences

1 a short-term hardship event during a
2 month if, for part or all of such month—

3 “(I) such individual receives in-
4 patient hospital services, nursing facil-
5 ity services, services in an inter-
6 mediate care facility for individuals
7 with intellectual disabilities, inpatient
8 psychiatric hospital services, or such
9 other services as the Secretary deter-
10 mines appropriate;

11 “(II) such individual resides in a
12 county (or equivalent unit of local
13 government)—

14 “(aa) in which there exists
15 an emergency or disaster de-
16 clared by the President pursuant
17 to the National Emergencies Act
18 or the Robert T. Stafford Dis-
19 aster Relief and Emergency As-
20 sistance Act; or

21 “(bb) that, subject to a re-
22 quest from the State to the Sec-
23 retary, made in such form, at
24 such time, and containing such
25 information as the Secretary may

1 require, has an unemployment
2 rate that is at or above the lesser
3 of—

4 “(AA) 8 percent; or
5 “(BB) 1.5 times the
6 national unemployment rate;
7 or

8 “(III) such individual experiences
9 any other short-term hardship (as de-
10 fined by the Secretary).

11 “(4) OPTION TO CONDUCT MORE FREQUENT
12 COMPLIANCE VERIFICATIONS.—With respect to an
13 applicable individual enrolled and receiving medical
14 assistance under a State plan (or a waiver of such
15 plan) under this title, the State shall verify (in ac-
16 cordance with procedures specified by the Secretary)
17 that each such individual has met the requirement
18 to demonstrate community engagement under para-
19 graph (1) during each such individual’s regularly
20 scheduled redetermination of eligibility, except that a
21 State may provide for such verifications more fre-
22 quently.

23 “(5) EX PARTE VERIFICATIONS.—For purposes
24 of verifying that an applicable individual has met the
25 requirement to demonstrate community engagement

1 under paragraph (1), the State shall, in accordance
2 with standards established by the Secretary, estab-
3 lish processes and use reliable information available
4 to the State (such as payroll data) without requir-
5 ing, where possible, the applicable individual to sub-
6 mit additional information.

7 “(6) PROCEDURE IN THE CASE OF NONCOMPLI-
8 ANCE.—

9 “(A) IN GENERAL.—If a State is unable to
10 verify that an applicable individual has met the
11 requirement to demonstrate community engage-
12 ment under paragraph (1) (including, if appli-
13 cable, by verifying that such individual was
14 deemed to have demonstrated community en-
15 gagement under paragraph (3)) the State shall
16 (in accordance with standards specified by the
17 Secretary)—

18 “(i) provide such individual with the
19 notice of noncompliance described in sub-
20 paragraph (B);

21 “(ii) (I) provide such individual with a
22 period of 30 calendar days, beginning on
23 the date on which such notice of non-
24 compliance is received by the individual,
25 to—

1 “(aa) make a satisfactory show-
2 ing to the State of compliance with
3 such requirement (including, if appli-
4 cable, by showing that such individual
5 was deemed to have demonstrated
6 community engagement under para-
7 graph (3)); or

8 “(bb) make a satisfactory show-
9 ing to the State that such require-
10 ment does not apply to such indi-
11 vidual on the basis that such indi-
12 vidual does not meet the definition of
13 applicable individual under paragraph
14 (9)(A); and

15 “(II) if such individual is enrolled
16 under the State plan (or a waiver of such
17 plan) under this title, continue to provide
18 such individual with medical assistance
19 during such 30-calendar-day period; and

20 “(iii) if no such satisfactory showing
21 is made and the individual is not a speci-
22 fied excluded individual described in para-
23 graph (9)(A)(ii), deny such individual’s ap-
24 plication for medical assistance under the
25 State plan (or waiver of such plan) or, as

1 applicable, disenroll such individual from
2 the plan (or waiver of such plan) not later
3 than the end of the month following the
4 month in which such 30-calendar-day pe-
5 riod ends, provided that—

6 “(I) the State first determines
7 whether, with respect to the indi-
8 vidual, there is any other basis for eli-
9 gibility for medical assistance under
10 the State plan (or waiver of such
11 plan) or for another insurance afford-
12 ability program; and

13 “(II) the individual is provided
14 written notice and granted an oppor-
15 tunity for a fair hearing in accordance
16 with subsection (a)(3).

17 “(B) NOTICE.—The notice of noncompli-
18 ance provided to an applicable individual under
19 subparagraph (A)(i) shall include information
20 (in accordance with standards specified by the
21 Secretary) on—

22 “(i) how such individual may make a
23 satisfactory showing of compliance with
24 such requirement (as described in subpara-
25 graph (A)(ii)) or make a satisfactory show-

1 ing that such requirement does not apply
2 to such individual on the basis that such
3 individual does not meet the definition of
4 applicable individual under paragraph
5 (9)(A); and

6 “(ii) how such individual may reapply
7 for medical assistance under the State plan
8 (or a waiver of such plan) under this title
9 in the case that such individuals’ applica-
10 tion is denied or, as applicable, in the case
11 that such individual is disenrolled from the
12 plan (or waiver).

13 “(7) TREATMENT OF NONCOMPLIANT INDIVID-
14 UALS IN RELATION TO CERTAIN OTHER PROVI-
15 SIONS.—

16 “(A) CERTAIN FMAP INCREASES.—A State
17 shall not be treated as not providing medical as-
18 sistance to all individuals described in section
19 1902(a)(10)(A)(i)(VIII), or as not expending
20 amounts for all such individuals under the
21 State plan (or waiver of such plan), solely be-
22 cause such an individual is determined ineligible
23 for medical assistance under the State plan (or
24 waiver) on the basis of a failure to meet the re-

1 quirement to demonstrate community engage-
2 ment under paragraph (1).

3 “(B) OTHER PROVISIONS.—For purposes
4 of section 36B(c)(2)(B) of the Internal Revenue
5 Code of 1986, an individual shall be deemed to
6 be eligible for minimum essential coverage de-
7 scribed in section 5000A(f)(1)(A)(ii) of such
8 Code for a month if such individual would have
9 been eligible for medical assistance under a
10 State plan (or a waiver of such plan) under this
11 title but for a failure to meet the requirement
12 to demonstrate community engagement under
13 paragraph (1).

14 “(8) OUTREACH.—

15 “(A) IN GENERAL.—In accordance with
16 standards specified by the Secretary, beginning
17 not later than October 1, 2028 (or, if earlier,
18 the date that precedes January 1, 2029, by the
19 number of months specified by the State under
20 paragraph (1)(A) plus 3 months), and periodi-
21 cally thereafter, the State shall notify applicable
22 individuals enrolled under a State plan (or
23 waiver) under this title of the requirement to
24 demonstrate community engagement under this

1 subsection. Such notice shall include informa-
2 tion on—

3 “(i) how to comply with such require-
4 ment, including an explanation of the ex-
5 ceptions to such requirement under para-
6 graph (3) and the definition of the term
7 ‘applicable individual’ under paragraph
8 (9)(A);

9 “(ii) the consequences of noncompli-
10 ance with such requirement; and

11 “(iii) how to report to the State any
12 change in the individual’s status that could
13 result in—

14 “(I) the applicability of an excep-
15 tion under paragraph (3) (or the end
16 of the applicability of such an excep-
17 tion); or

18 “(II) the individual qualifying as
19 a specified excluded individual under
20 paragraph (9)(A)(ii).

21 “(B) FORM OF OUTREACH NOTICE.—A no-
22 tice required under subparagraph (A) shall be
23 delivered—

1 “(i) by regular mail (or, if elected by
2 the individual, in an electronic format);
3 and

4 “(ii) in 1 or more additional forms,
5 which may include telephone, text message,
6 an internet website, other commonly avail-
7 able electronic means, and such other
8 forms as the Secretary determines appro-
9 priate.

10 “(9) DEFINITIONS.—In this subsection:

11 “(A) APPLICABLE INDIVIDUAL.—

12 “(i) IN GENERAL.—The term ‘applica-
13 ble individual’ means an individual (other
14 than a specified excluded individual (as de-
15 fined in clause (ii)))—

16 “(I) who is eligible to enroll (or
17 is enrolled) under the State plan
18 under subsection (a)(10)(A)(i)(VIII);
19 or

20 “(II) who—

21 “(aa) is otherwise eligible to
22 enroll (or is enrolled) under a
23 waiver of such plan that provides
24 coverage that is equivalent to
25 minimum essential coverage (as

1 described in section
2 5000A(f)(1)(A) of the Internal
3 Revenue Code of 1986 and as de-
4 termined in accordance with
5 standards prescribed by the Sec-
6 retary in regulations); and

7 “(bb) has attained the age
8 of 19 and is under 65 years of
9 age, is not pregnant, is not enti-
10 tled to, or enrolled for, benefits
11 under part A of title XVIII, or
12 enrolled for benefits under part
13 B of title XVIII, and is not oth-
14 erwise eligible to enroll under
15 such plan.

16 “(ii) SPECIFIED EXCLUDED INDIVIDUAL.—For purposes of clause (i), the
17 term ‘specified excluded individual’ means
18 an individual, as determined by the State
19 (in accordance with standards specified by
20 the Secretary)—

22 “(I) who is described in sub-
23 section (a)(10)(A)(i)(IX);

24 “(II) who—

1 “(aa) is an Indian or an
2 Urban Indian (as such terms are
3 defined in paragraphs (13) and
4 (28) of section 4 of the Indian
5 Health Care Improvement Act);

6 “(bb) is a California Indian
7 described in section 809(a) of
8 such Act; or

9 “(cc) has otherwise been de-
10 termined eligible as an Indian for
11 the Indian Health Service under
12 regulations promulgated by the
13 Secretary;

14 “(III) who is the parent, guard-
15 ian, or caretaker relative of a disabled
16 individual or a dependent child;

17 “(IV) who is a veteran with a
18 disability rated as total under section
19 1155 of title 38, United States Code;

20 “(V) who is medically frail or
21 otherwise has special medical needs
22 (as defined by the Secretary), includ-
23 ing an individual—

1 “(aa) who is blind or dis-
2 abled (as defined in section
3 1614);

4 “(bb) with a substance use
5 disorder;

6 “(cc) with a disabling men-
7 tal disorder;

8 “(dd) with a physical, intel-
9 lectual or developmental dis-
10 ability that significantly impairs
11 their ability to perform 1 or more
12 activities of daily living;

13 “(ee) with a serious and
14 complex medical condition; or

15 “(ff) subject to the approval
16 of the Secretary, with any other
17 medical condition identified by
18 the State that is not otherwise
19 identified under this clause;

20 “(VI) who—

21 “(aa) is in compliance with
22 any requirements imposed by the
23 State pursuant to section 407; or

24 “(bb) is a member of a
25 household that receives supple-

1 mental nutrition assistance pro-
2 gram benefits under the Food
3 and Nutrition Act of 2008 and is
4 not exempt from a work require-
5 ment under such Act;

6 “(VII) who is participating in a
7 drug addiction or alcoholic treatment
8 and rehabilitation program (as defined
9 in section 3(h) of the Food and Nutri-
10 tion Act of 2008);

11 “(VIII) who is an inmate of a
12 public institution; or

13 “(IX) who meets such other cri-
14 teria as the Secretary determines ap-
15 propriate.

16 “(B) EDUCATIONAL PROGRAM.—The term
17 ‘educational program’ means—

18 “(i) an institution of higher education
19 (as defined in section 101 of the Higher
20 Education Act of 1965);

21 “(ii) a program of career and tech-
22 nical education (as defined in section 3 of
23 the Carl D. Perkins Career and Technical
24 Education Act of 2006); or

1 “(iii) any other educational program
2 that meets such criteria as the Secretary
3 determines appropriate.

4 “(C) STATE.—The term ‘State’ means 1 of
5 the 50 States or the District of Columbia.

6 “(D) WORK PROGRAM.—The term ‘work
7 program’ has the meaning given such term in
8 section 6(o)(1) of the Food and Nutrition Act
9 of 2008.

10 “(10) PROHIBITING WAIVER OF COMMUNITY
11 ENGAGEMENT REQUIREMENTS.—Notwithstanding
12 section 1115(a), the provisions of this subsection
13 may not be waived.”.

14 (b) CONFORMING AMENDMENT.—Section
15 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42
16 U.S.C. 1396a(a)(10)(A)(i)(VIII)) is amended by striking
17 “subject to subsection (k)” and inserting “subject to sub-
18 sections (k) and (xx)”.

19 (c) RULEMAKING.—Not later than July 1, 2027, the
20 Secretary of Health and Human Services shall promulgate
21 regulations for purposes of carrying out the amendments
22 made by this section.

23 (d) GRANTS TO STATES.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services shall, out of amounts appropriated

1 under paragraph (3), award to each State a grant
2 equal to the amount specified in paragraph (2) for
3 such State for purposes of establishing systems nec-
4 essary to carry out the provisions of, and amend-
5 ments made by, this section.

6 (2) AMOUNT SPECIFIED.—For purposes of
7 paragraph (2), the amount specified in this para-
8 graph is an amount that bears the same ratio to the
9 amount appropriated under paragraph (3) as the
10 number of applicable individuals (as defined in sec-
11 tion 1902(xx) of the Social Security Act, as added
12 by subsection (a)) residing in such State bears to
13 the total number of such individuals residing in all
14 States.

15 (3) FUNDING.—There are appropriated, out of
16 any monies in the Treasury not otherwise appro-
17 priated, \$100,000,000 for fiscal year 2026 for pur-
18 poses of awarding grants under paragraph (1).

19 (4) DEFINITION.—In this subsection, the term
20 “State” means 1 of the 50 States and the District
21 of Columbia.

22 (e) IMPLEMENTATION FUNDING.—For the purposes
23 of carrying out the provisions of, and the amendments
24 made by, this section, there are appropriated, out of any
25 monies in the Treasury not otherwise appropriated, to the

1 Secretary of Health and Human Services, \$50,000,000 for
2 fiscal year 2026, to remain available until expended.

3 **SEC. 44142. MODIFYING COST SHARING REQUIREMENTS**
4 **FOR CERTAIN EXPANSION INDIVIDUALS**
5 **UNDER THE MEDICAID PROGRAM.**

6 (a) IN GENERAL.—Section 1916 of the Social Secu-
7 rity Act (42 U.S.C. 1396o) is amended—

8 (1) in subsection (a), in the matter preceding
9 paragraph (1), by inserting “(other than, beginning
10 October 1, 2028, specified individuals (as defined in
11 subsection (k)(3)))” after “individuals”; and

12 (2) by adding at the end the following new sub-
13 section:

14 “(k) SPECIAL RULES FOR CERTAIN EXPANSION IN-
15 DIVIDUALS.—

16 “(1) PREMIUMS.—Beginning October 1, 2028,
17 the State plan shall provide that in the case of a
18 specified individual (as defined in paragraph (3))
19 who is eligible under the plan, no enrollment fee,
20 premium, or similar charge will be imposed under
21 the plan.

22 “(2) REQUIRED IMPOSITION OF COST SHAR-
23 ING.—

24 “(A) IN GENERAL.—Subject to subpara-
25 graph (B) and subsection (j), in the case of a

1 specified individual, the State plan shall, begin-
2 ning October 1, 2028, provide for the imposi-
3 tion of such deductions, cost sharing, or similar
4 charges determined appropriate by the State (in
5 an amount greater than \$0) with respect to
6 medical assistance furnished to such an indi-
7 vidual.

8 “(B) LIMITATIONS.—

9 “(i) EXCLUSION OF CERTAIN SERV-
10 ICES.—In no case may a deduction, cost
11 sharing, or similar charge be imposed
12 under the State plan with respect to serv-
13 ices described in any of subparagraphs (B)
14 through (J) of subsection (a)(2) furnished
15 to a specified individual.

16 “(ii) ITEM AND SERVICE LIMITA-
17 TION.—

18 “(I) IN GENERAL.—Except as
19 provided in subclause (II), in no case
20 may a deduction, cost sharing, or
21 similar charge imposed under the
22 State plan with respect to an item or
23 service furnished to a specified indi-
24 vidual exceed \$35.

1 “(II) SPECIAL RULES FOR PRE-
2SCRIPTION DRUGS.—In no case may a
3deduction, cost sharing, or similar
4charge imposed under the State plan
5with respect to a prescription drug
6furnished to a specified individual ex-
7ceed the limit that would be applicable
8under paragraph (2)(A)(i) or (2)(B)
9of section 1916A(c) with respect to
10such drug and individual if such drug
11so furnished were subject to cost shar-
12ing under such section.

13 “(iii) MAXIMUM LIMIT ON COST SHAR-
14ING.—The total aggregate amount of de-
15ductions, cost sharing, or similar charges
16imposed under the State plan for all indi-
17viduals in the family may not exceed 5 per-
18cent of the family income of the family in-
19volved, as applied on a quarterly or month-
20ly basis (as specified by the State).

21 “(C) CASES OF NONPAYMENT.—Notwith-
22standing subsection (e) or any other provision
23of law, a State may permit a provider partici-
24pating under the State plan to require, as a
25condition for the provision of care, items, or

1 services to a specified individual entitled to
2 medical assistance under this title for such
3 care, items, or services, the payment of any de-
4 ductions, cost sharing, or similar charges au-
5 thorized to be imposed with respect to such
6 care, items, or services. Nothing in this sub-
7 paragraph shall be construed as preventing a
8 provider from reducing or waiving the applica-
9 tion of such deductions, cost sharing, or similar
10 charges on a case-by-case basis.

11 “(3) SPECIFIED INDIVIDUAL DEFINED.—For
12 purposes of this subsection, the term ‘specified indi-
13 vidual’ means an individual enrolled under section
14 1902(a)(10)(A)(i)(VIII) who has a family income (as
15 determined in accordance with section 1902(e)(14))
16 that exceeds the poverty line (as defined in section
17 2110(c)(5)) applicable to a family of the size in-
18 volved.”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) REQUIRED APPLICATION.—Section
21 1902(a)(14) of the Social Security Act (42 U.S.C.
22 1396a(a)(14)) is amended by inserting “and provide
23 for imposition of such deductions, cost sharing, or
24 similar charges for medical assistance furnished to
25 specified individuals (as defined in paragraph (3) of

1 section 1916(k)) in accordance with paragraph (2)
2 of such section” after “section 1916”.

3 (2) NONAPPLICABILITY OF ALTERNATIVE COST
4 SHARING.—Section 1916A(a)(1) of the Social Secu-
5 rity Act (42 U.S.C. 1396o–1(a)(1)) is amended, in
6 the second sentence, by striking “or (j)” and insert-
7 ing “(j), or (k)”.

8 **PART 2—AFFORDABLE CARE ACT**

9 **SEC. 44201. ADDRESSING WASTE, FRAUD, AND ABUSE IN**
10 **THE ACA EXCHANGES.**

11 (a) CHANGES TO ENROLLMENT PERIODS FOR EN-
12 ROLLING IN EXCHANGES.—Section 1311 of the Patient
13 Protection and Affordable Care Act (42 U.S.C. 18031) is
14 amended—

15 (1) in subsection (c)(6)—

16 (A) by striking subparagraph (A);

17 (B) by striking “The Secretary” and in-
18 serting the following:

19 “(A) IN GENERAL.—The Secretary”;

20 (C) by redesignating subparagraphs (B)
21 through (D) as clauses (i) through (iii), respec-
22 tively, and adjusting the margins accordingly;

23 (D) in clause (i), as so redesignated, by
24 striking “periods, as determined by the Sec-
25 retary for calendar years after the initial enroll-

1 ment period;” and inserting the following: “pe-
2 riods for plans offered in the individual mar-
3 ket—

4 “(I) for enrollment for plan years
5 beginning before January 1, 2026, as
6 determined by the Secretary; and

7 “(II) for enrollment for plan
8 years beginning on or after January
9 1, 2026, beginning on November 1
10 and ending on December 15 of the
11 preceding calendar year;”;

12 (E) in clause (ii), as so redesignated, by
13 inserting “subject to subparagraph (B),” before
14 “special enrollment periods specified”; and

15 (F) by adding at the end the following new
16 subparagraph:

17 “(B) PROHIBITED SPECIAL ENROLLMENT
18 PERIOD.—With respect to plan years beginning
19 on or after January 1, 2026, the Secretary may
20 not require an Exchange to provide for a spe-
21 cial enrollment period for an individual on the
22 basis of the relationship of the income of such
23 individual to the poverty line, other than a spe-
24 cial enrollment period based on a change in cir-

1 cumstances or the occurrence of a specific
2 event.”; and

3 (2) in subsection (d), by adding at the end the
4 following new paragraphs:

5 “(8) PROHIBITED ENROLLMENT PERIODS.—An
6 Exchange may not provide for, with respect to en-
7 rollment for plan years beginning on or after Janu-
8 ary 1, 2026—

9 “(A) an annual open enrollment period
10 other than the period described in subpara-
11 graph (A)(i) of subsection (c)(6); or

12 “(B) a special enrollment period described
13 in subparagraph (B) of such subsection.

14 “(9) VERIFICATION OF ELIGIBILITY FOR SPE-
15 CIAL ENROLLMENT PERIODS.—

16 “(A) IN GENERAL.—With respect to enroll-
17 ment for plan years beginning on or after Janu-
18 ary 1, 2026, an Exchange shall verify that each
19 individual seeking to enroll in a qualified health
20 plan offered by the Exchange during a special
21 enrollment period selected under subparagraph
22 (B) is eligible to enroll during such special en-
23 rollment period prior to enrolling such indi-
24 vidual in such plan.

1 “(B) SELECTED SPECIAL ENROLLMENT
2 PERIODS.—For purposes of subparagraph (A),
3 an Exchange shall select one or more special
4 enrollment periods for a plan year with respect
5 to which such Exchange shall conduct the
6 verification required under subparagraph (A)
7 such that the Exchange conducts such
8 verification for not less than 75 percent of all
9 individuals enrolling in a qualified health plan
10 offered by the Exchange during any special en-
11 rollment period with respect to such plan
12 year.”.

13 (b) VERIFYING INCOME FOR INDIVIDUALS ENROLL-
14 ING IN A QUALIFIED HEALTH PLAN THROUGH AN EX-
15 CHANGE.—

16 (1) IN GENERAL.—Section 1411(e)(4) of the
17 Patient Protection and Affordable Care Act (42
18 U.S.C. 18081(e)(4)) is amended—

19 (A) by redesignating subparagraph (C) as
20 subparagraph (E); and

21 (B) by inserting after subparagraph (B)
22 the following new subparagraphs:

23 “(C) REQUIRING VERIFICATION OF IN-
24 COME AND FAMILY SIZE WHEN TAX DATA IS
25 UNAVAILABLE.—For plan years beginning on or

1 after January 1, 2026, for purposes of subpara-
2 graph (A), in the case that the Exchange re-
3 quests data from the Secretary of the Treasury
4 regarding an individual's household income and
5 the Secretary of the Treasury does not return
6 such data, such information may not be verified
7 solely on the basis of the attestation of such in-
8 dividual with respect to such household income,
9 and the Exchange shall take the actions de-
10 scribed in subparagraph (A).

11 “(D) REQUIRING VERIFICATION OF IN-
12 COME IN THE CASE OF CERTAIN INCOME DIS-
13 CREPANCIES.—

14 “(i) IN GENERAL.—Subject to clause
15 (iii), for plan years beginning on or after
16 January 1, 2026, for purposes of subpara-
17 graph (A), in the case that a specified in-
18 come discrepancy described in clause (ii) of
19 this subparagraph exists with respect to
20 the information provided by an applicant
21 under subsection (b)(3), the household in-
22 come of such individual shall be treated as
23 inconsistent with information in the
24 records maintained by persons under sub-
25 section (c), or as not verified under sub-

1 section (d), and the Exchange shall take
2 the actions described in such subparagraph
3 (A).

4 “(ii) SPECIFIED INCOME DISCREP-
5 ANCY.—For purposes of clause (i), a speci-
6 fied income discrepancy exists with respect
7 to the information provided by an appli-
8 cant under subsection (b)(3) if—

9 “(I) the applicant attests to a
10 projected annual household income
11 that would qualify such applicant to
12 be an applicable taxpayer under sec-
13 tion 36B(c)(1)(A) of the Internal Rev-
14 enue Code of 1986 with respect to the
15 taxable year involved;

16 “(II) the Exchange receives data
17 from the Secretary of the Treasury or
18 the Commissioner of Social Security,
19 or other reliable, third party data,
20 that indicates that the household in-
21 come of such applicant is less than
22 the household income that would qual-
23 ify such applicant to be an applicable
24 taxpayer under such section

1 36B(c)(1)(A) with respect to the tax-
2 able year involved;

3 “(III) such attested projected an-
4 nual household income exceeds the in-
5 come reflected in the data described in
6 subclause (II) by a reasonable thresh-
7 old established by the Exchange and
8 approved by the Secretary (which
9 shall be not less than 10 percent, and
10 may also be a dollar amount); and

11 “(IV) the Exchange has not as-
12 sessed or determined based on the
13 data described in subclause (II) that
14 the household income of the applicant
15 meets the applicable income-based eli-
16 gibility standard for the Medicaid pro-
17 gram under title XIX of the Social
18 Security Act or the State children’s
19 health insurance program under title
20 XXI of such Act.

21 “(iii) EXCLUSION OF CERTAIN INDI-
22 VIDUALS INELIGIBLE FOR MEDICAID.—
23 This subparagraph shall not apply in the
24 case of an applicant who is an alien law-
25 fully present in the United States, who is

1 not eligible for the Medicaid program
2 under title XIX of the Social Security Act
3 by reason of such alien status.”.

4 (2) REQUIRING INDIVIDUALS ON WHOSE BE-
5 HALF ADVANCE PAYMENTS OF THE PREMIUM TAX
6 CREDITS ARE MADE TO FILE AND RECONCILE ON AN
7 ANNUAL BASIS.—Section 1412(b) of the Patient
8 Protection and Affordable Care Act (42 U.S.C.
9 18082(b)) is amended by adding at the end the fol-
10 lowing new paragraph:

11 “(3) ANNUAL REQUIREMENT TO FILE AND REC-
12 ONCILE.—

13 “(A) IN GENERAL.—For plan years begin-
14 ning on or after January 1, 2026, in the case
15 of an individual with respect to whom any ad-
16 vance payment of the premium tax credit allow-
17 able under section 36B of the Internal Revenue
18 Code of 1986 was made under this section to
19 the issuer of a qualified health plan for the rel-
20 evant prior tax year, an advance determination
21 of eligibility for such premium tax credit may
22 not be made under this subsection with respect
23 to such individual and such plan year if the Ex-
24 change determines, based on information pro-

1 vided by the Secretary of the Treasury, that
2 such individual—

3 “(i) has not filed an income tax re-
4 turn, as required under sections 6011 and
5 6012 of such Code (and implementing reg-
6 ulations), for the relevant prior tax year;
7 or

8 “(ii) as necessary, has not reconciled
9 (in accordance with subsection (f) of such
10 section 36B) the advance payment of the
11 premium tax credit made with respect to
12 such individual for such relevant prior tax
13 year.

14 “(B) RELEVANT PRIOR TAX YEAR.—For
15 purposes of subparagraph (A), the term ‘rel-
16 evant prior tax year’ means, with respect to the
17 advance determination of eligibility made under
18 this subsection with respect to an individual,
19 the taxable year for which tax return data
20 would be used for purposes of verifying the
21 household income and family size of such indi-
22 vidual (as described in section 1411(b)(3)(A)).

23 “(C) PRELIMINARY ATTESTATION.—If an
24 individual subject to subparagraph (A) attests
25 that such individual has fulfilled the require-

1 ments to file an income tax return for the rel-
2 evant prior tax year and, as necessary, to rec-
3 oncile the advance payment of the premium tax
4 credit made with respect to such individual for
5 such relevant prior tax year (as described in
6 clauses (i) and (ii) of such subparagraph), the
7 Secretary may make an initial advance deter-
8 mination of eligibility with respect to such indi-
9 vidual and may delay for a reasonable period
10 (as determined by the Secretary) any deter-
11 mination based on information provided by the
12 Secretary of the Treasury that such individual
13 has not fulfilled such requirements.

14 “(D) NOTICE.—If the Secretary deter-
15 mines that an individual did not meet the re-
16 quirements described in subparagraph (A) with
17 respect to the relevant prior tax year and noti-
18 fies the Exchange of such determination, the
19 Exchange shall comply with the notification re-
20 quirement described in section 155.305(f)(4)(i)
21 of title 45, Code of Federal Regulations (as in
22 effect with respect to plan year 2025).”.

23 (3) REMOVING AUTOMATIC EXTENSION OF PE-
24 RIOD TO RESOLVE INCOME INCONSISTENCIES.—The
25 Secretary of Health and Human Services shall revise

1 section 155.315(f) of title 45, Code of Federal Regu-
2 lations (or any successor regulation), to remove
3 paragraph (7) of such section such that, with respect
4 to enrollment for plan years beginning on or after
5 January 1, 2026, in the case that an Exchange es-
6 tablished under subtitle D of title I of the Patient
7 Protection and Affordable Care Act (42 U.S.C.
8 18021 et seq.) provides an individual applying for
9 enrollment in a qualified health plan with a 90-day
10 period to resolve an inconsistency in the application
11 of such individual pursuant to section
12 1411(e)(4)(A)(ii)(II) of such Act, the Exchange may
13 not provide for an automatic extension to such 90-
14 day period on the basis that such individual is re-
15 quired to present satisfactory documentary evidence
16 to verify household income.

17 (c) REVISING RULES ON ALLOWABLE VARIATION IN
18 ACTUARIAL VALUE OF HEALTH PLANS.—The Secretary
19 of Health and Human Services shall—

20 (1) revise section 156.140(c) of title 45, Code
21 of Federal Regulations (or a successor regulation),
22 to provide that, for plan years beginning on or after
23 January 1, 2026, the allowable variation in the actu-
24 arial value of a health plan applicable under such

1 section shall be the allowable variation for such plan
2 applicable under such section for plan year 2022;

3 (2) revise section 156.200(b)(3) of title 45,
4 Code of Federal Regulations (or a successor regula-
5 tion), to provide that, for plan years beginning on or
6 after January 1, 2026, the requirement for a quali-
7 fied health plan issuer described in such section is
8 that the issuer ensures that each qualified health
9 plan complies with benefit design standards, as de-
10 fined in section 156.20 of such title; and

11 (3) revise section 156.400 of title 45, Code of
12 Federal Regulations (or a successor regulation), to
13 provide that, for plan years beginning on or after
14 January 1, 2026, the term “de minimis variation for
15 a silver plan variation” means a minus 1 percentage
16 point and plus 1 percentage point allowable actuarial
17 value variation.

18 (d) UPDATING PREMIUM ADJUSTMENT PERCENTAGE
19 METHODOLOGY.—Section 1302(c)(4) of the Patient Pro-
20 tection and Affordable Care Act (42 U.S.C. 18022(c)(4))
21 is amended—

22 (1) by striking “For purposes” and inserting:

23 “(A) IN GENERAL.—For purposes”; and

24 (2) by adding at the end the following new sub-
25 paragraph:

1 “(B) UPDATE TO METHODOLOGY.—For
2 calendar years beginning with 2026, the pre-
3 mium adjustment percentage under this para-
4 graph for such calendar year shall be deter-
5 mined consistent with the methodology pub-
6 lished in the Federal Register on April 25,
7 2019 (84 Fed. Reg. 17537 through 17541).”.

8 (e) ELIMINATING THE FIXED-DOLLAR AND GROSS-
9 PERCENTAGE THRESHOLDS APPLICABLE TO EXCHANGE
10 ENROLLMENTS.—The Secretary of Health and Human
11 Services shall revise section 155.400(g) of title 45, Code
12 of Federal Regulations (or a successor regulation) to
13 eliminate, for plan years beginning on or after January
14 1, 2026, the gross premium percentage-based premium
15 payment threshold policy described in paragraph (2) of
16 such section and the fixed-dollar premium payment
17 threshold policy described in paragraph (3) of such sec-
18 tion.

19 (f) PROHIBITING AUTOMATIC REENROLLMENT FROM
20 BRONZE TO SILVER LEVEL QUALIFIED HEALTH PLANS
21 OFFERED BY EXCHANGES.—The Secretary of Health and
22 Human Services shall revise section 155.335(j) of title 45,
23 Code of Federal Regulations (or any successor regulation)
24 to remove paragraph (4) of such section such that, with
25 respect to reenrollments for plan years beginning on or

1 after January 1, 2026, an Exchange established under
2 subtitle D of title I of the Patient Protection and Afford-
3 able Care Act (42 U.S.C. 18021 et seq.) may not reenroll
4 an individual who was enrolled in a bronze level qualified
5 health plan in a silver level qualified health plan (as such
6 terms are defined in section 1301(a) and described in
7 1302(d) of such Act) unless otherwise permitted under
8 section 155.335(j) of title 45, Code of Federal Regula-
9 tions, as in effect on the day before the date of the enact-
10 ment of this section.

11 (g) REDUCING ADVANCE PAYMENTS OF PREMIUM
12 TAX CREDITS FOR CERTAIN INDIVIDUALS REENROLLED
13 IN EXCHANGES.—Section 1412 of the Patient Protection
14 and Affordable Care Act (42 U.S.C. 18082) is amended—

15 (1) in subsection (a)(3), by inserting “, subject
16 to subsection (c)(2)(C),” after “qualified health
17 plans”; and

18 (2) in subsection (c)(2)—

19 (A) in subparagraph (A), by striking
20 “The” and inserting “Subject to subparagraph
21 (C), the”; and

22 (B) by adding at the end the following new
23 subparagraph:

24 “(C) REDUCTION IN ADVANCE PAYMENT
25 FOR SPECIFIED REENROLLED INDIVIDUALS.—

1 “(i) IN GENERAL.—The amount of an
2 advance payment made under subpara-
3 graph (A) to reduce the premium payable
4 for a qualified health plan that provides
5 coverage to a specified reenrolled individual
6 for an applicable month shall be an
7 amount equal to the amount that would
8 otherwise be made under such subpara-
9 graph reduced by \$5 (or such higher
10 amount as the Secretary determines appro-
11 priate).

12 “(ii) DEFINITIONS.—In this subpara-
13 graph:

14 “(I) APPLICABLE MONTH.—The
15 term ‘applicable month’ means, with
16 respect to a specified reenrolled indi-
17 vidual, any month during a plan year
18 beginning on or after January 1,
19 2027 (or, in the case of an individual
20 reenrolled in a qualified health plan
21 by an Exchange established pursuant
22 to section 1321(c), January 1, 2026)
23 if, prior to the first day of such
24 month, such individual has failed to
25 confirm or update such information as

1 is necessary to redetermine the eligi-
2 bility of such individual for such plan
3 year pursuant to section 1411(f).

4 “(II) SPECIFIED REENROLLED
5 INDIVIDUAL.—The term ‘specified re-
6 enrolled individual’ means an indi-
7 vidual who is reenrolled in a qualified
8 health plan and with respect to whom
9 the advance payment made under sub-
10 paragraph (A) would, without applica-
11 tion of any reduction under this sub-
12 paragraph, reduce the premium pay-
13 able for a qualified health plan that
14 provides coverage to such an indi-
15 vidual to \$0.”.

16 (h) PROHIBITING COVERAGE OF GENDER TRANSI-
17 TION PROCEDURES AS AN ESSENTIAL HEALTH BENEFIT
18 UNDER PLANS OFFERED BY EXCHANGES.—

19 (1) IN GENERAL.—Section 1302(b)(2) of the
20 Patient Protection and Affordable Care Act (42
21 U.S.C. 18022(b)(2)) is amended by adding at the
22 end the following new subparagraph:

23 “(C) GENDER TRANSITION PROCE-
24 DURES.—For plan years beginning on or after
25 January 1, 2027, the essential health benefits

1 defined pursuant to paragraph (1) may not in-
2 clude items and services furnished for a gender
3 transition procedure.”.

4 (2) GENDER TRANSITION PROCEDURE DE-
5 FINED.—Section 1304 of the Patient Protection and
6 Affordable Care Act (42 U.S.C. 18024) is amended
7 by adding at the end the following new subsection:
8 “(f) GENDER TRANSITION PROCEDURE.—

9 “(1) IN GENERAL.—In this title, except as pro-
10 vided in paragraph (2), the term ‘gender transition
11 procedure’ means, with respect to an individual, any
12 of the following when performed for the purpose of
13 intentionally changing the body of such individual
14 (including by disrupting the body’s development, in-
15 hibiting its natural functions, or modifying its ap-
16 pearance) to no longer correspond to the individual’s
17 sex:

18 “(A) Performing any surgery, including—

19 “(i) castration;

20 “(ii) sterilization;

21 “(iii) orchiectomy;

22 “(iv) scrotoplasty;

23 “(v) vasectomy;

24 “(vi) tubal ligation;

25 “(vii) hysterectomy;

- 1 “(viii) oophorectomy;
2 “(ix) ovariectomy;
3 “(x) metoidioplasty;
4 “(xi) clitoroplasty;
5 “(xii) reconstruction of the fixed part
6 of the urethra with or without a
7 metoidioplasty or a phalloplasty;
8 “(xiii) penectomy;
9 “(xiv) phalloplasty;
10 “(xv) vaginoplasty;
11 “(xvi) vaginectomy;
12 “(xvii) vulvoplasty;
13 “(xviii) reduction thyrochondroplasty;
14 “(xix) chondrolaryngoplasty;
15 “(xx) mastectomy; and
16 “(xxi) any plastic, cosmetic, or aes-
17 thetic surgery that feminizes or
18 masculinizes the facial or other body fea-
19 tures of an individual.
20 “(B) Any placement of chest implants to
21 create feminine breasts or any placement of
22 erection or testicular protheseses.
23 “(C) Any placement of fat or artificial im-
24 plants in the gluteal region.

1 “(D) Administering, prescribing, or dis-
2 pensing to an individual medications, includ-
3 ing—

4 “(i) gonadotropin-releasing hormone
5 (GnRH) analogues or other puberty-block-
6 ing drugs to stop or delay normal puberty;
7 and

8 “(ii) testosterone, estrogen, or other
9 androgens to an individual at doses that
10 are supraphysiologic than would normally
11 be produced endogenously in a healthy in-
12 dividual of the same age and sex.

13 “(2) EXCEPTION.—Paragraph (1) shall not
14 apply to the following:

15 “(A) Puberty suppression or blocking pre-
16 scription drugs for the purpose of normalizing
17 puberty for an individual experiencing pre-
18 cocious puberty.

19 “(B) Medically necessary procedures or
20 treatments to correct for—

21 “(i) a medically verifiable disorder of
22 sex development, including—

23 “(I) 46,XX chromosomes with
24 virilization;

1 “(II) 46,XY chromosomes with
2 undervirilization; and

3 “(III) both ovarian and testicular
4 tissue;

5 “(ii) sex chromosome structure, sex
6 steroid hormone production, or sex hor-
7 mone action, if determined to be abnormal
8 by a physician through genetic or bio-
9 chemical testing;

10 “(iii) infection, disease, injury, or dis-
11 order caused or exacerbated by a previous
12 procedure described in paragraph (1), or a
13 physical disorder, physical injury, or phys-
14 ical illness that would, as certified by a
15 physician, place the individual in imminent
16 danger of death or impairment of a major
17 bodily function unless the procedure is per-
18 formed, not including procedures per-
19 formed for the alleviation of mental dis-
20 tress; or

21 “(iv) procedures to restore or recon-
22 struct the body of the individual in order
23 to correspond to the individual’s sex after
24 one or more previous procedures described
25 in paragraph (1), which may include the

1 removal of a pseudo phallus or breast aug-
2 mentation.

3 “(3) SEX.—For purposes of this subsection, the
4 term ‘sex’ means either male or female, as bio-
5 logically determined and defined by subparagraph
6 (A) and subparagraph (B).

7 “(A) FEMALE.—The term ‘female’ means
8 an individual who naturally has, had, will have,
9 or would have, but for a developmental or ge-
10 netic anomaly or historical accident, the repro-
11 ductive system that at some point produces,
12 transports, and utilizes eggs for fertilization.

13 “(B) MALE.—The term ‘male’ means an
14 individual who naturally has, had, will have, or
15 would have, but for a developmental or genetic
16 anomaly or historical accident, the reproductive
17 system that at some point produces, transports,
18 and utilizes sperm for fertilization.”.

19 (i) CLARIFYING LAWFUL PRESENCE FOR PURPOSES
20 OF THE EXCHANGES.—

21 (1) IN GENERAL.—Section 1312(f) of the Pa-
22 tient Protection and Affordable Care Act (42 U.S.C.
23 18032(f)) is amended by adding at the end the fol-
24 lowing new paragraph:

1 “(4) CLARIFICATION OF LAWFUL PRESENCE.—

2 In this title, the term ‘alien lawfully present in the
3 United States’ does not include an alien granted de-
4 ferred action under the Deferred Action for Child-
5 hood Arrivals process pursuant to the memorandum
6 of the Department of Homeland Security entitled
7 ‘Exercising Prosecutorial Discretion with Respect to
8 Individuals Who Came to the United States as Chil-
9 dren’ issued on June 15, 2012.”.

10 (2) COST-SHARING REDUCTIONS.—Section
11 1402(e)(2) of the Patient Protection and Affordable
12 Care Act (42 U.S.C. 18071(e)(2)) is amended by
13 adding at the end the following new sentence: “For
14 purposes of this section, an individual shall not be
15 treated as lawfully present if the individual is an
16 alien granted deferred action under the Deferred Ac-
17 tion for Childhood Arrivals process pursuant to the
18 memorandum of the Department of Homeland Secu-
19 rity entitled ‘Exercising Prosecutorial Discretion
20 with Respect to Individuals Who Came to the United
21 States as Children’ issued on June 15, 2012.”.

22 (3) PAYMENT PROHIBITION.—Section 1412(d)
23 of the Patient Protection and Affordable Care Act
24 (42 U.S.C. 18082(d)) is amended by adding at the
25 end the following new sentence: “For purposes of

1 the previous sentence, an individual shall not be
2 treated as lawfully present if the individual is an
3 alien granted deferred action under the Deferred Ac-
4 tion for Childhood Arrivals process pursuant to the
5 memorandum of the Department of Homeland Secu-
6 rity entitled ‘Exercising Prosecutorial Discretion
7 with Respect to Individuals Who Came to the United
8 States as Children’ issued on June 15, 2012.”.

9 (4) EFFECTIVE DATE.—The amendments made
10 by this section shall apply with respect to plan years
11 beginning on or after January 1, 2026.

12 (j) ENSURING APPROPRIATE APPLICATION OF GUAR-
13 ANTEED ISSUE REQUIREMENTS IN CASE OF NON-
14 PAYMENT OF PAST PREMIUMS.—

15 (1) IN GENERAL.—Section 2702 of the Public
16 Health Service Act (42 U.S.C. 300gg–1) is amended
17 by adding at the end the following new subsection:
18 “(e) NONPAYMENT OF PAST PREMIUMS.—

19 “(1) IN GENERAL.—A health insurance issuer
20 offering individual health insurance coverage may, to
21 the extent allowed under State law, deny such cov-
22 erage in the case of an individual who owes any
23 amount for premiums for individual health insurance
24 coverage offered by such issuer (or by a health in-
25 surance issuer in the same controlled group (as de-

1 fined in paragraph (3)) as such issuer) in which
2 such individual was previously enrolled.

3 “(2) ATTRIBUTION OF INITIAL PREMIUM PAY-
4 MENT TO OWED AMOUNT.—A health insurance
5 issuer offering individual health insurance coverage
6 may, in the case of an individual described in para-
7 graph (1) and to the extent allowed under State law,
8 attribute the initial premium payment for such cov-
9 erage applicable to such individual to the amount
10 owed by such individual for premiums for individual
11 health insurance coverage offered by such issuer (or
12 by a health insurance issuer in the same controlled
13 group as such issuer) in which such individual was
14 previously enrolled.

15 “(3) CONTROLLED GROUP DEFINED.—For pur-
16 poses of this subsection, the term ‘controlled group’
17 means a group of of two or more persons that is
18 treated as a single employer under section 52(a),
19 52(b), 414(m), or 414(o) of the Internal Revenue
20 Code of 1986.”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply with respect to plan
23 years beginning on or after January 1, 2026.

1 **PART 3—IMPROVING AMERICANS’ ACCESS TO**
2 **CARE**

3 **SEC. 44301. EXPANDING AND CLARIFYING THE EXCLUSION**
4 **FOR ORPHAN DRUGS UNDER THE DRUG**
5 **PRICE NEGOTIATION PROGRAM.**

6 (a) IN GENERAL.—Section 1192(e) of the Social Se-
7 curity Act (42 U.S.C. 1320f–1(e)) is amended—

8 (1) in paragraph (1), by adding at the end the
9 following new subparagraph:

10 “(C) TREATMENT OF FORMER ORPHAN
11 DRUGS.—In calculating the amount of time that
12 has elapsed with respect to the approval of a
13 drug or licensure of a biological product under
14 subparagraph (A)(ii) and subparagraph (B)(ii),
15 respectively, the Secretary shall not take into
16 account any period during which such drug or
17 product was a drug described in paragraph
18 (3)(A).”; and

19 (2) in paragraph (3)(A)—

20 (A) by striking “only one rare disease or
21 condition” and inserting “one or more rare dis-
22 eases or conditions”; and

23 (B) by striking “such disease or condition”
24 and inserting “one or more rare diseases or
25 conditions (as such term is defined in section

1 526(a)(2) of the Federal Food, Drug, and Cos-
2 metic Act)’’.

3 (b) APPLICATION.—The amendments made by sub-
4 section (a) shall apply with respect to initial price applica-
5 bility years (as defined in section 1191(b) of the Social
6 Security Act (42 U.S.C. 1320f(b))) beginning on or after
7 January 1, 2028.

8 **SEC. 44302. STREAMLINED ENROLLMENT PROCESS FOR EL-**
9 **IGIBLE OUT-OF-STATE PROVIDERS UNDER**
10 **MEDICAID AND CHIP.**

11 (a) IN GENERAL.—Section 1902(kk) of the Social Se-
12 curity Act (42 U.S.C. 1396a(kk)) is amended by adding
13 at the end the following new paragraph:

14 “(10) STREAMLINED ENROLLMENT PROCESS
15 FOR ELIGIBLE OUT-OF-STATE PROVIDERS.—

16 “(A) IN GENERAL.—The State—

17 “(i) adopts and implements a process
18 to allow an eligible out-of-State provider to
19 enroll under the State plan (or a waiver of
20 such plan) to furnish items and services to,
21 or order, prescribe, refer, or certify eligi-
22 bility for items and services for, qualifying
23 individuals without the imposition of
24 screening or enrollment requirements by
25 such State that exceed the minimum nec-

1 essary for such State to provide payment
2 to an eligible out-of-State provider under
3 such State plan (or a waiver of such plan),
4 such as the provider’s name and National
5 Provider Identifier (and such other infor-
6 mation specified by the Secretary); and

7 “(ii) provides that an eligible out-of-
8 State provider that enrolls as a partici-
9 pating provider in the State plan (or a
10 waiver of such plan) through such process
11 shall be so enrolled for a 5-year period, un-
12 less the provider is terminated or excluded
13 from participation during such period.

14 “(B) DEFINITIONS.—In this paragraph:

15 “(i) ELIGIBLE OUT-OF-STATE PRO-
16 VIDER.—The term ‘eligible out-of-State
17 provider’ means, with respect to a State, a
18 provider—

19 “(I) that is located in any other
20 State;

21 “(II) that—

22 “(aa) was determined by the
23 Secretary to have a limited risk
24 of fraud, waste, and abuse for
25 purposes of determining the level

1 of screening to be conducted
2 under section 1866(j)(2), has
3 been so screened under such sec-
4 tion 1866(j)(2), and is enrolled in
5 the Medicare program under title
6 XVIII; or

7 “(bb) was determined by the
8 State agency administering or su-
9 pervising the administration of
10 the State plan (or a waiver of
11 such plan) of such other State to
12 have a limited risk of fraud,
13 waste, and abuse for purposes of
14 determining the level of screening
15 to be conducted under paragraph
16 (1) of this subsection, has been
17 so screened under such para-
18 graph (1), and is enrolled under
19 such State plan (or a waiver of
20 such plan); and

21 “(III) that has not been—

22 “(aa) excluded from partici-
23 pation in any Federal health care
24 program pursuant to section
25 1128 or 1128A;

1 “(bb) excluded from partici-
2 pation in the State plan (or a
3 waiver of such plan) pursuant to
4 part 1002 of title 42, Code of
5 Federal Regulations (or any suc-
6 cessor regulation), or State law;
7 or

8 “(cc) terminated from par-
9 ticipating in a Federal health
10 care program or the State plan
11 (or a waiver of such plan) for a
12 reason described in paragraph
13 (8)(A).

14 “(ii) QUALIFYING INDIVIDUAL.—The
15 term ‘qualifying individual’ means an indi-
16 vidual under 21 years of age who is en-
17 rolled under the State plan (or waiver of
18 such plan).

19 “(iii) STATE.—The term ‘State’
20 means 1 of the 50 States or the District
21 of Columbia.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) Section 1902(a)(77) of the Social Security
24 Act (42 U.S.C. 1396a(a)(77)) is amended by insert-
25 ing “enrollment,” after “screening,”.

1 (2) The subsection heading for section
2 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is
3 amended by inserting “enrollment,” after “screen-
4 ing,”.

5 (3) Section 2107(e)(1)(G) of such Act (42
6 U.S.C. 1397gg(e)(1)(G)) is amended by inserting
7 “enrollment,” after “screening,”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply beginning on the date that is 4
10 years after the date of enactment of this Act.

11 **SEC. 44303. DELAYING DSH REDUCTIONS.**

12 (a) IN GENERAL.—Section 1923(f) of the Social Se-
13 curity Act (42 U.S.C. 1396r-4(f)) is amended—

14 (1) in paragraph (7)(A)—

15 (A) in clause (i)—

16 (i) in the matter preceding subclause
17 (I), by striking “2026 through 2028” and
18 inserting “2029 through 2031”; and

19 (ii) in subclause (II), by striking “or
20 period”; and

21 (B) in clause (ii), by striking “2026
22 through 2028” and inserting “2029 through
23 2031”; and

24 (2) in paragraph (8), by striking “2027” and
25 inserting “2031”.

1 (b) TENNESSEE DSH ALLOTMENT.—Section
2 1923(f)(6)(A)(vi) of the Social Security Act (42 U.S.C.
3 1396r-4(f)(6)(A)(vi)) is amended—

4 (1) in the header, by striking “2025” and insert-
5 ing “2028”; and

6 (2) by striking “fiscal year 2025” and inserting
7 “fiscal year 2028”.

8 **SEC. 44304. MODIFYING UPDATE TO THE CONVERSION FAC-**
9 **TOR UNDER THE PHYSICIAN FEE SCHEDULE**
10 **UNDER THE MEDICARE PROGRAM.**

11 Section 1848(d) of the Social Security Act (42 U.S.C.
12 1395w-4(d)) is amended—

13 (1) in paragraph (1)—

14 (A) in subparagraph (A)—

15 (i) in the first sentence, by striking
16 “and ending with 2025”; and

17 (ii) by striking the second sentence;
18 and

19 (B) in subparagraph (D), by striking “(or,
20 beginning with 2026, applicable conversion fac-
21 tor)”; and

22 (2) by amending paragraph (20) to read as fol-
23 lows:

1 “(20) UPDATE FOR 2026 AND SUBSEQUENT
2 YEARS.—The update to the single conversion factor
3 established in paragraph (1)(A)—

4 “(A) for 2026 is 75 percent of the Sec-
5 retary’s estimate of the percentage increase in
6 the MEI (as defined in section 1842(i)(3)) for
7 the year; and

8 “(B) for 2027 and each subsequent year is
9 10 percent of the Secretary’s estimate of the
10 percentage increase in the MEI for the year.”.

11 **SEC. 44305. MODERNIZING AND ENSURING PBM ACCOUNT-**
12 **ABILITY.**

13 (a) IN GENERAL.—

14 (1) PRESCRIPTION DRUG PLANS.—Section
15 1860D–12 of the Social Security Act (42 U.S.C.
16 1395w–112) is amended by adding at the end the
17 following new subsection:

18 “(h) REQUIREMENTS RELATING TO PHARMACY BEN-
19 EFIT MANAGERS.—For plan years beginning on or after
20 January 1, 2028:

21 “(1) AGREEMENTS WITH PHARMACY BENEFIT
22 MANAGERS.—Each contract entered into with a
23 PDP sponsor under this part with respect to a pre-
24 scription drug plan offered by such sponsor shall
25 provide that any pharmacy benefit manager acting

1 on behalf of such sponsor has a written agreement
2 with the PDP sponsor under which the pharmacy
3 benefit manager, and any affiliates of such phar-
4 macy benefit manager, as applicable, agree to meet
5 the following requirements:

6 “(A) NO INCOME OTHER THAN BONA FIDE
7 SERVICE FEES.—

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

17 “(ii) INCENTIVE PAYMENTS.—For the
18 purposes of this subsection, an incentive
19 payment (as determined by the Secretary)
20 paid by a PDP sponsor to a pharmacy
21 benefit manager (or an affiliate of such
22 pharmacy benefit manager) that is per-
23 forming services on behalf of such sponsor
24 shall be deemed a ‘bona fide service fee’
25 (even if such payment does not otherwise

1 meet the definition of such term under
2 paragraph (7)(B)) if such payment is a
3 flat dollar amount, is consistent with fair
4 market value (as specified by the Sec-
5 retary), is related to services actually per-
6 formed by the pharmacy benefit manager
7 or affiliate of such pharmacy benefit man-
8 ager, on behalf of the PDP sponsor mak-
9 ing such payment, in connection with the
10 utilization of covered part D drugs, and
11 meets additional requirements, if any, as
12 determined appropriate by the Secretary.

13 “(iii) CLARIFICATION ON REBATES
14 AND DISCOUNTS USED TO LOWER COSTS
15 FOR COVERED PART D DRUGS.—Rebates,
16 discounts, and other price concessions re-
17 ceived by a pharmacy benefit manager or
18 an affiliate of a pharmacy benefit manager
19 from manufacturers, even if such price
20 concessions are calculated as a percentage
21 of a drug’s price, shall not be considered a
22 violation of the requirements of clause (i)
23 if they are fully passed through to a PDP
24 sponsor and are compliant with all regu-
25 latory and subregulatory requirements re-

lated 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 benefit 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 appro-

1 prie by the Secretary. The Secretary, in
2 consultation with the Office of the Inspec-
3 tor General, shall review whether remu-
4 neration under such arrangements is con-
5 sistent with fair market value (as specified
6 by the Secretary) through reviews and as-
7 sessments of such remuneration, as deter-
8 mined appropriate.

9 “(v) DISGORGEMENT.—The pharmacy
10 benefit manager shall disgorge any remu-
11 neration paid to such pharmacy benefit
12 manager or an affiliate of such pharmacy
13 benefit manager in violation of this sub-
14 paragraph to the PDP sponsor.

15 “(vi) ADDITIONAL REQUIREMENTS.—
16 The pharmacy benefit manager shall—

17 “(I) enter into a written agree-
18 ment with any affiliate of such phar-
19 macy benefit manager, under which
20 the affiliate shall identify and disgorge
21 any remuneration described in clause
22 (v) to the pharmacy benefit manager;
23 and

24 “(II) attest, subject to any re-
25 quirements determined appropriate by

1 the Secretary, that the pharmacy ben-
2 efit manager has entered into a writ-
3 ten agreement described in subclause
4 (I) with any relevant affiliate of the
5 pharmacy benefit manager.

6 “(B) TRANSPARENCY REGARDING GUARAN-
7 TEES AND COST PERFORMANCE EVALUA-
8 TIONS.—The pharmacy benefit manager shall—

9 “(i) define, interpret, and apply, in a
10 fully transparent and consistent manner
11 for purposes of calculating or otherwise
12 evaluating pharmacy benefit manager per-
13 formance against pricing guarantees or
14 similar cost performance measurements re-
15 lated to rebates, discounts, price conces-
16 sions, or net costs, terms such as—

17 “(I) ‘generic drug’, in a manner
18 consistent with the definition of the
19 term under section 423.4 of title 42,
20 Code of Federal Regulations, or a suc-
21 cessor regulation;

22 “(II) ‘brand name drug’, in a
23 manner consistent with the definition
24 of the term under section 423.4 of

1 title 42, Code of Federal Regulations,
2 or a successor regulation;

3 “(III) ‘specialty drug’;

4 “(IV) ‘rebate’; and

5 “(V) ‘discount’;

6 “(ii) identify any drugs, claims, or
7 price concessions excluded from any pric-
8 ing guarantee or other cost performance
9 measure in a clear and consistent manner;
10 and

11 “(iii) where a pricing guarantee or
12 other cost performance measure is based
13 on a pricing benchmark other than the
14 wholesale acquisition cost (as defined in
15 section 1847A(c)(6)(B)) of a drug, cal-
16 culate and provide a wholesale acquisition
17 cost-based equivalent to the pricing guar-
18 antee or other cost performance measure.

19 “(C) PROVISION OF INFORMATION.—

20 “(i) IN GENERAL.—Not later than
21 July 1 of each year, beginning in 2028, the
22 pharmacy benefit manager shall submit to
23 the PDP sponsor, and to the Secretary, a
24 report, in accordance with this subpara-
25 graph, and shall make such report avail-

1 able to such sponsor at no cost to such
2 sponsor in a format specified by the Sec-
3 retary under paragraph (5). Each such re-
4 port shall include, with respect to such
5 PDP sponsor and each plan offered by
6 such sponsor, the following information
7 with respect to the previous plan year:

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

11 “(aa) the brand name, ge-
12 neric or non-proprietary name,
13 and National Drug Code;

14 “(bb) the number of plan
15 enrollees for whom the drug was
16 dispensed, the total number of
17 prescription claims for the drug
18 (including original prescriptions
19 and refills, counted as separate
20 claims), and the total number of
21 dosage units of the drug dis-
22 pensed;

23 “(cc) the number of pre-
24 scription claims described in item
25 (bb) by each type of dispensing

1 channel through which the drug
2 was dispensed, including retail,
3 mail order, specialty pharmacy,
4 long term care pharmacy, home
5 infusion pharmacy, or other types
6 of pharmacies or providers;

7 “(dd) the average wholesale
8 acquisition cost, listed as cost per
9 day’s supply, cost per dosage
10 unit, and cost per typical course
11 of treatment (as applicable);

12 “(ee) the average wholesale
13 price for the drug, listed as price
14 per day’s supply, price per dos-
15 age unit, and price per typical
16 course of treatment (as applica-
17 ble);

18 “(ff) the total out-of-pocket
19 spending by plan enrollees on
20 such drug after application of
21 any benefits under the plan, in-
22 cluding plan enrollee spending
23 through copayments, coinsurance,
24 and deductibles;

1 “(gg) total rebates paid by
2 the manufacturer on the drug as
3 reported under the Detailed DIR
4 Report (or any successor report)
5 submitted by such sponsor to the
6 Centers for Medicare & Medicaid
7 Services;

8 “(hh) all other direct or in-
9 direct remuneration on the drug
10 as reported under the Detailed
11 DIR Report (or any successor re-
12 port) submitted by such sponsor
13 to the Centers for Medicare &
14 Medicaid Services;

15 “(ii) the average pharmacy
16 reimbursement amount paid by
17 the plan for the drug in the ag-
18 gregate and disaggregated by dis-
19 pensing channel identified in item
20 (cc);

21 “(jj) the average National
22 Average Drug Acquisition Cost
23 (NADAC); and

24 “(kk) total manufacturer-de-
25 rived revenue, inclusive of bona

1 fide service fees, attributable to
2 the drug and retained by the
3 pharmacy benefit manager and
4 any affiliate of such pharmacy
5 benefit manager.

6 “(II) In the case of a pharmacy
7 benefit manager that has an affiliate
8 that is a retail, mail order, or spe-
9 cialty pharmacy, with respect to drugs
10 covered by such plan that were dis-
11 pensed, the following information:

12 “(aa) The percentage of
13 total prescriptions that were dis-
14 pensed by pharmacies that are an
15 affiliate of the pharmacy benefit
16 manager for each drug.

17 “(bb) The interquartile
18 range of the total combined costs
19 paid by the plan and plan enroll-
20 ees, per dosage unit, per course
21 of treatment, per 30-day supply,
22 and per 90-day supply for each
23 drug dispensed by pharmacies
24 that are not an affiliate of the
25 pharmacy benefit manager and

1 that are included in the phar-
2 macy network of such plan.

3 “(cc) The interquartile
4 range of the total combined costs
5 paid by the plan and plan enroll-
6 ees, per dosage unit, per course
7 of treatment, per 30-day supply,
8 and per 90-day supply for each
9 drug dispensed by pharmacies
10 that are an affiliate of the phar-
11 macy benefit manager and that
12 are included in the pharmacy
13 network of such plan.

14 “(dd) The lowest total com-
15 bined cost paid by the plan and
16 plan enrollees, per dosage unit,
17 per course of treatment, per 30-
18 day supply, and per 90-day sup-
19 ply, for each drug that is avail-
20 able from any pharmacy included
21 in the pharmacy network of such
22 plan.

23 “(ee) The difference between
24 the average acquisition cost of
25 the affiliate, such as a pharmacy

1 or other entity that acquires pre-
2 scription drugs, that initially ac-
3 quires the drug and the amount
4 reported under subclause (I)(jj)
5 for each drug.

6 “(ff) A list inclusive of the
7 brand name, generic or non-pro-
8 prietary name, and National
9 Drug Code of covered part D
10 drugs subject to an agreement
11 with a covered entity under sec-
12 tion 340B of the Public Health
13 Service Act for which the phar-
14 macy benefit manager or an affil-
15 iate of the pharmacy benefit
16 manager had a contract or other
17 arrangement with such a covered
18 entity in the service area of such
19 plan.

20 “(III) Where a drug approved
21 under section 505(c) of the Federal
22 Food, Drug, and Cosmetic Act (re-
23 ferred to in this subclause as the ‘list-
24 ed drug’) is covered by the plan, the
25 following information:

1 “(aa) A list of currently
2 marketed generic drugs approved
3 under section 505(j) of the Fed-
4 eral Food, Drug, and Cosmetic
5 Act pursuant to an application
6 that references such listed drug
7 that are not covered by the plan,
8 are covered on the same for-
9 mulary tier or a formulary tier
10 typically associated with higher
11 cost-sharing than the listed drug,
12 or are subject to utilization man-
13 agement that the listed drug is
14 not subject to.

15 “(bb) The estimated average
16 beneficiary cost-sharing under
17 the plan for a 30-day supply of
18 the listed drug.

19 “(cc) Where a generic drug
20 listed under item (aa) is on a for-
21 mulary tier typically associated
22 with higher cost-sharing than the
23 listed drug, the estimated aver-
24 age cost-sharing that a bene-
25 ficiary would have paid for a 30-

1 day supply of each of the generic
2 drugs described in item (aa), had
3 the plan provided coverage for
4 such drugs on the same for-
5 mulary tier as the listed drug.

6 “(dd) A written justification
7 for providing more favorable cov-
8 erage of the listed drug than the
9 generic drugs described in item
10 (aa).

11 “(ee) The number of cur-
12 rently marketed generic drugs
13 approved under section 505(j) of
14 the Federal Food, Drug, and
15 Cosmetic Act pursuant to an ap-
16 plication that references such
17 listed drug.

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

22 “(aa) A list of currently
23 marketed biosimilar biological
24 products licensed under section
25 351(k) of the Public Health

1 Service Act pursuant to an appli-
2 cation that refers to such ref-
3 erence product that are not cov-
4 ered by the plan, are covered on
5 the same formulary tier or a for-
6 mulary tier typically associated
7 with higher cost-sharing than the
8 reference product, or are subject
9 to utilization management that
10 the reference product is not sub-
11 ject to.

12 “(bb) The estimated average
13 beneficiary cost-sharing under
14 the plan for a 30-day supply of
15 the reference product.

16 “(cc) Where a biosimilar bi-
17 ological product listed under item
18 (aa) is on a formulary tier typi-
19 cally associated with higher cost-
20 sharing than the reference prod-
21 uct, the estimated average cost-
22 sharing that a beneficiary would
23 have paid for a 30-day supply of
24 each of the biosimilar biological
25 products described in item (aa),

1 had the plan provided coverage
2 for such products on the same
3 formulary tier as the reference
4 product.

5 “(dd) A written justification
6 for providing more favorable cov-
7 erage of the reference product
8 than the biosimilar biological
9 product described in item (aa).

10 “(ee) The number of cur-
11 rently marketed biosimilar bio-
12 logical products licensed under
13 section 351(k) of the Public
14 Health Service Act, pursuant to
15 an application that refers to such
16 reference product.

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

21 “(VI) The total amount retained
22 by the pharmacy benefit manager or
23 an affiliate of such pharmacy benefit
24 manager in revenue related to utiliza-
25 tion of covered part D drugs under

1 that plan, inclusive of bona fide serv-
2 ice fees.

3 “(VII) The total spending on cov-
4 ered part D drugs net of rebates, fees,
5 discounts, or other direct and indirect
6 remuneration by the plan.

7 “(VIII) An explanation of any
8 benefit design parameters under such
9 plan that encourage plan enrollees to
10 fill prescriptions at pharmacies that
11 are an affiliate of such pharmacy ben-
12 efit manager, such as mail and spe-
13 cialty home delivery programs, and re-
14 tail and mail auto-refill programs.

15 “(IX) The following information:

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

1 “(bb) The amount of com-
2 pensation provided by such phar-
3 macy benefit manager or affiliate
4 to each such broker, consultant,
5 advisor, and auditor.

6 “(cc) The methodology for
7 calculating the amount of com-
8 pensation provided by such phar-
9 macy benefit manager or affil-
10 iate, for each such broker, con-
11 sultant, advisor, and auditor.

12 “(X) A list of all affiliates of the
13 pharmacy benefit manager.

14 “(XI) A summary document sub-
15 mitted in a standardized template de-
16 veloped by the Secretary that includes
17 such information described in sub-
18 clauses (I) through (X).

19 “(ii) WRITTEN EXPLANATION OF CON-
20 TRACTS OR AGREEMENTS WITH DRUG
21 MANUFACTURERS.—

22 “(I) IN GENERAL.—The phar-
23 macy benefit manager shall, not later
24 than 30 days after the finalization of
25 any contract or agreement between

1 such pharmacy benefit manager or an
2 affiliate of such pharmacy benefit
3 manager and a drug manufacturer (or
4 subsidiary, agent, or entity affiliated
5 with such drug manufacturer) that
6 makes rebates, discounts, payments,
7 or other financial incentives related to
8 one or more covered part D drugs or
9 other prescription drugs, as applica-
10 ble, of the manufacturer directly or
11 indirectly contingent upon coverage,
12 formulary placement, or utilization
13 management conditions on any other
14 covered part D drugs or other pre-
15 scription drugs, as applicable, submit
16 to the PDP sponsor a written expla-
17 nation of such contract or agreement.

18 “(II) REQUIREMENTS.—A writ-
19 ten explanation under subclause (I)
20 shall—

21 “(aa) include the manufac-
22 turer subject to the contract or
23 agreement, all covered part D
24 drugs and other prescription
25 drugs, as applicable, subject to

1 the contract or agreement and
2 the manufacturers of such drugs,
3 and a high-level description of
4 the terms of such contract or
5 agreement and how such terms
6 apply to such drugs; and

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

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

25 “(D) AUDIT RIGHTS.—

1 “(i) IN GENERAL.—Not less than once
2 a year, at the request of the PDP sponsor,
3 the pharmacy benefit manager shall allow
4 for an audit of the pharmacy benefit man-
5 ager to ensure compliance with all terms
6 and conditions under the written agree-
7 ment described in this paragraph and the
8 accuracy of information reported under
9 subparagraph (C).

10 “(ii) AUDITOR.—The PDP sponsor
11 shall have the right to select an auditor.
12 The pharmacy benefit manager shall not
13 impose any limitations on the selection of
14 such auditor.

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

24 “(iv) TIMING.—The pharmacy benefit
25 manager must provide information under

1 clause (iii) and other information, data,
2 and records relevant to the audit to such
3 auditor within 6 months of the initiation of
4 the audit and respond to requests for addi-
5 tional information from such auditor with-
6 in 30 days after the request for additional
7 information.

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

16 “(2) ENFORCEMENT.—

17 “(A) IN GENERAL.—Each PDP sponsor
18 shall—

19 “(i) disgorge to the Secretary any
20 amounts disgorged to the PDP sponsor by
21 a pharmacy benefit manager under para-
22 graph (1)(A)(v);

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

1 such pharmacy benefit manager, that such
2 pharmacy benefit manager or affiliate re-
3 imburse the PDP sponsor for any civil
4 money penalty imposed on the PDP spon-
5 sor as a result of the failure of the phar-
6 macy benefit manager or affiliate to meet
7 the requirements of paragraph (1) that are
8 applicable to the pharmacy benefit man-
9 ager or affiliate under the agreement; and
10 “(iii) require, in a written agreement
11 with any such pharmacy benefit manager
12 acting on behalf of such sponsor or affil-
13 iate of such pharmacy benefit manager,
14 that such pharmacy benefit manager or af-
15 filiate be subject to punitive remedies for
16 breach of contract for failure to comply
17 with the requirements applicable under
18 paragraph (1).

19 “(B) REPORTING OF ALLEGED VIOLA-
20 TIONS.—The Secretary shall make available and
21 maintain a mechanism for manufacturers, PDP
22 sponsors, pharmacies, and other entities that
23 have contractual relationships with pharmacy
24 benefit managers or affiliates of such pharmacy
25 benefit managers to report, on a confidential

1 basis, alleged violations of paragraph (1)(A) or
2 subparagraph (C).

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

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

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

13 “(3) CERTIFICATION OF COMPLIANCE.—

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

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

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

1 “(A) prohibiting flat dispensing fees or re-
2 imbursement or payment for ingredient costs
3 (including customary, industry-standard dis-
4 counts directly related to drug acquisition that
5 are retained by pharmacies or wholesalers) to
6 entities that acquire or dispense prescription
7 drugs; or

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

12 “(5) STANDARD FORMATS.—

13 “(A) IN GENERAL.—Not later than June
14 1, 2027, the Secretary shall specify standard,
15 machine-readable formats for pharmacy benefit
16 managers to submit annual reports required
17 under paragraph (1)(C)(i).

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 “(6) CONFIDENTIALITY.—

23 “(A) IN GENERAL.—Information disclosed
24 by a pharmacy benefit manager, an affiliate of
25 a pharmacy benefit manager, a PDP sponsor,

1 or a pharmacy under this subsection that is not
2 otherwise publicly available or available for pur-
3 chase shall not be disclosed by the Secretary or
4 a PDP sponsor receiving the information, ex-
5 cept that the Secretary may disclose the infor-
6 mation for the following purposes:

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

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

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

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

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

21 “(vi) To the Inspector General of the
22 Department of Health and Human Serv-
23 ices in accordance with its authorities
24 under the Inspector General Act of 1978

1 (section 406 of title 5, United States
2 Code), and other applicable statutes.

3 “(B) RESTRICTION ON USE OF INFORMA-
4 TION.—The Secretary, the Comptroller General,
5 the Director of the Congressional Budget Of-
6 fice, and the Executive Director of the Medicare
7 Payment Advisory Commission shall not report
8 on or disclose information disclosed pursuant to
9 subparagraph (A) to the public in a manner
10 that would identify—

11 “(i) a specific pharmacy benefit man-
12 ager, affiliate, pharmacy, manufacturer,
13 wholesaler, PDP sponsor, or plan; or

14 “(ii) contract prices, rebates, dis-
15 counts, or other remuneration for specific
16 drugs in a manner that may allow the
17 identification of specific contracting parties
18 or of such specific drugs.

19 “(7) DEFINITIONS.—For purposes of this sub-
20 section:

21 “(A) AFFILIATE.—The term ‘affiliate’
22 means, with respect to any pharmacy benefit
23 manager or PDP sponsor, any entity that, di-
24 rectly or indirectly—

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

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

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

1 “(i) drug price, such as wholesale ac-
2 quisition cost or drug benchmark price
3 (such as average wholesale price);

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

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

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

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

1 essing of drug prior authorization requests, the
2 adjudication of appeals or grievances related to
3 the prescription drug benefit, contracting with
4 network pharmacies, controlling the cost of cov-
5 ered part D drugs, or the provision of related
6 services. Such term includes any person or enti-
7 ty that carries out one or more of the activities
8 described in the preceding sentence, irrespective
9 of whether such person or entity calls itself a
10 ‘pharmacy benefit manager’.”.

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

15 “(F) REQUIREMENTS RELATING TO PHAR-
16 MACY BENEFIT MANAGERS.—For plan years be-
17 ginning on or after January 1, 2028, section
18 1860D–12(h).”.

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

23 (4) FUNDING.—

24 (A) SECRETARY.—In addition to amounts
25 otherwise available, there is appropriated to the

1 Centers for Medicare & Medicaid Services Pro-
2 gram Management Account, out of any money
3 in the Treasury not otherwise appropriated,
4 \$113,000,000 for fiscal year 2025, to remain
5 available until expended, to carry out this sub-
6 section.

7 (B) OIG.—In addition to amounts other-
8 wise available, there is appropriated to the In-
9 spector General of the Department of Health
10 and Human Services, out of any money in the
11 Treasury not otherwise appropriated,
12 \$20,000,000 for fiscal year 2025, to remain
13 available until expended, to carry out this sub-
14 section.

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

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

1 perts, to the extent available, with respect to the fol-
2 lowing:

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

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

22 (I) advise PDP sponsors offering
23 prescription drug plans and Medicare
24 Advantage organizations offering MA–

1 PD plans regarding pharmacy bene-
2 fits; or

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

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

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

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

24 (D) Potential conflicts of interest among
25 contracting entities related to the use of pre-

1 scription drug price-related compensation struc-
2 tures, such as the potential for fees or other
3 payments set as a percentage of a prescription
4 drug's price to advantage formulary selection,
5 distribution, or purchasing of prescription drugs
6 with higher prices.

7 (E) Notable differences, if any, in the use
8 and level of price-based compensation struc-
9 tures over time and between different market
10 segments, such as under part D of title XVIII
11 of the Social Security Act (42 U.S.C. 1395w-
12 101 et seq.) and the Medicaid program under
13 title XIX of such Act (42 U.S.C. 1396 et seq.).

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

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

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

10 (c) MEDPAC REPORTS ON AGREEMENTS WITH
11 PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-
12 SCRIPTIION DRUG PLANS AND MA-PD PLANS.—

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

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

24 (i) a description of trends and pat-
25 terns, including relevant averages, totals,

1 and other figures for the types of informa-
2 tion submitted;

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

8 (iii) any recommendations the Com-
9 mission determines appropriate.

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

18 (2) FUNDING.—In addition to amounts other-
19 wise available, there is appropriated to the Medicare
20 Payment Advisory Commission, out of any money in
21 the Treasury not otherwise appropriated,
22 \$1,000,000 for fiscal year 2026, to remain available
23 until expended, to carry out this subsection.