Committee Print

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

TITLE IV—ENERGY AND COMMERCE

Subtitle D—Health

PART 1—MEDICAID

Subpart A—Reducing Fraud and Improving Enrollment Processes

SEC. 44101. MORATORIUM ON IMPLEMENTATION OF RULE RELATING TO ELIGIBILITY AND ENROLLMENT IN MEDICARE SAVINGS PROGRAMS.

The Secretary of Health and Human Services shall not, during the period beginning on the date of the enactment of this section and ending January 1, 2035, implement, administer, or enforce the provisions of the final rule published by the Centers for Medicare & Medicaid Services on September 21, 2023, and titled ''Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment'' (88 Fed. Reg. 65230).

SEC. 44102. MORATORIUM ON IMPLEMENTATION OF RULE RELATING TO ELIGIBILITY AND ENROLLMENT FOR MEDICAID, CHIP, AND THE BASIC HEALTH PROGRAM.

The Secretary of Health and Human Services shall not, during the period beginning on the date of the enactment of this section and ending January 1, 2035, implement, administer, or enforce the provisions of the final rule published by the Centers for Medicare & Medicaid Services on April 2, 2024, and titled ''Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes'' (89 Fed. Reg. 22780).

SEC. 44103. ENSURING APPROPRIATE ADDRESS VERIFICATION UNDER THE MEDICAID AND CHIP PROGRAMS.

(a) MEDICAID.—

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

(A) in subsection (a)—

(i) in paragraph (86), by striking ''and'' at the end;

(ii) in paragraph (87), by striking the period and inserting ''; and''; and

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

''(88) provide—

''(A) beginning not later than January 1, 2027, in the case of 1 of the 50 States and the District of Columbia, for a process to regularly obtain address information for individuals enrolled under such plan (or a waiver of such plan) in accordance with subsection (vv); and

''(B) beginning not later than October 1, 2029—

''(i) for the State to submit to the system established by the Secretary under subsection (uu), with respect to an individual enrolled or seeking to enroll under such plan, not less frequently than once each month and during each determination or redetermination of the eligibility of such individual for medical assistance under such plan (or waiver of such plan)—

''(I) the social security number of such individual, if such individual has a social security number and is required to provide such number to enroll under such plan (or waiver); and

''(II) such other information with respect to such individual as determined necessary by the Secretary for purposes of preventing individuals from simultaneously being enrolled under State plans (or waivers of such plans) of multiple States;

''(ii) for the use of such system to prevent such simultaneous enrollment; and

''(iii) in the case that such system indicates that an individual enrolled or seeking to enroll under such plan (or wavier of such plan) is enrolled under a State plan (or waiver of such a plan) of another State, for the taking of appropriate action (as determined by the Secretary) to identify whether such an individual resides in the State and disenroll an individual from the State plan of such State if such individual does not reside in such State (unless such individual meets such an exception as the Secretary may specify).''; and

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

''(uu) PREVENTION OF ENROLLMENT UNDER MULTIPLE STATE PLANS.—

''(1) IN GENERAL.—Not later than October 1, 2029, the Secretary shall establish a system to be utilized by the Secretary and States to prevent an individual from being simultaneously enrolled under the State plans (or waivers of such plans) of multiple States. Such system shall—

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

''(B) not less than once each month, notify or transmit information to a State (or allow the Secretary to notify or transmit information to a State) regarding whether an individual enrolled or seeking to enroll under the State plan of such State (or waiver of such plan) is enrolled under the State plan (or waiver of such plan) of another State.

''(2) STANDARDS.—The Secretary shall establish such standards as determined necessary by the Secretary to limit and protect information submitted under such system and ensure the privacy of such information, consistent with subsection (a)(7).

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

''(A) for fiscal year 2026, $10,000,000 for purposes of establishing the system required under this subsection, to remain available until expended; and

''(B) for fiscal year 2029, $20,000,000 for purposes of maintaining such system, to remain available until expended.

''(vv) PROCESS TO OBTAIN ENROLLEE ADDRESS INFORMATION.—

''(1) IN GENERAL.—For purposes of subsection (a)(88)(A), a process to regularly obtain address information for individuals enrolled under a State plan (or a waiver of such plan) shall obtain address information from reliable data sources described in paragraph (2) and take such actions as the Secretary shall specify with respect to any changes to such address based on such information.

''(2) RELIABLE DATA SOURCES DESCRIBED.—For purposes of paragraph (1), the reliable data sources described in this paragraph are the following:

''(A) Mail returned to the State by the United States Postal Service with a forwarding address.

''(B) The National Change of Address Database maintained by the United States Postal Service.

''(C) A managed care entity (as defined in section 1932(a)(1)(B)) or prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section 1903(m)(9)(D)) that has a contract under the State plan if the address information is provided to such entity or plan directly from, or verified by such entity or plan directly with, such individual.

''(D) Other data sources as identified by the State and approved by the Secretary.''.

(2) CONFORMING AMENDMENTS.—

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

(i) by striking ''In order'' and inserting ''(A) In order'';

(ii) by striking ''through the Public'' and inserting ''through—

''(i) the Public'';

(iii) by striking the period at the end and inserting ''; and

''(ii) beginning October 1, 2029, the system established by the Secretary under section 1902(uu).''; and

(iv) by adding at the end the following new subparagraph:

''(B) Beginning October 1, 2029, the Secretary may determine that a State is not required to have in operation an eligibility determination system which provides for data matching through the system described in subparagraph (A)(i) to meet the requirements of this paragraph.''.

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

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

information for an individual enrolled with such entity or plan that is provided to such entity or plan directly from, or verified by such entity or plan directly with, such individual.''.

(b) CHIP.—

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

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

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

''(H) Section 1902(a)(88) (relating to address information for enrollees and prevention of simultaneous enrollments).''.

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

SEC. 44104. MODIFYING CERTAIN STATE REQUIREMENTS FOR ENSURING DECEASED INDIVIDUALS DO NOT REMAIN ENROLLED.

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

(1) in subsection (a)—

(A) in paragraph (87), by striking ''; and'' and inserting a semicolon;

(B) in paragraph (88), by striking the period at the end and inserting ''; and''; and

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

''(89) provide that the State shall comply with the eligibility verification requirements under subsection (ww), except that this paragraph shall apply only in the case of the 50 States and the District of Columbia.''; and

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

''(ww) VERIFICATION OF CERTAIN ELIGIBILITY CRITERIA.—

''(1) IN GENERAL.—For purposes of subsection (a)(89), the eligibility verification requirements, beginning January 1, 2028, are as follows:

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

''(B) DISENROLLMENT UNDER STATE PLAN.—If the State determines, based on information obtained from the Death Master File, that an individual enrolled for medical assistance under the State plan (or waiver of such plan) is deceased, the State shall—

''(i) treat such information as factual information confirming the death of a beneficiary for purposes of section 431.213(a) of title 42, Code of Federal Regulations (or any successor regulation);

''(ii) disenroll such individual from the State plan (or waiver of such plan); and

''(iii) discontinue any payments for medical assistance under this title made on behalf of such individual (other than payments for any items or services furnished

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

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

''(2) RULE OF CONSTRUCTION.—Nothing under this subsection shall be construed to preclude the ability of a State to use other electronic data sources to timely identify potentially deceased beneficiaries, so long as the State is also in compliance with the requirements of this subsection (and all other requirements under this title relating to Medicaid eligibility determination and redetermination).''.

SEC. 44105. MEDICAID PROVIDER SCREENING REQUIREMENTS.

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

(1) by striking ''The State'' and inserting:

''(A) IN GENERAL.—The State''; and

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

''(B) ADDITIONAL PROVIDER SCREENING.—Beginning January 1, 2028, as part of the enrollment (or reenrollment or revalidation of enrollment) of a provider or supplier under this title, and not less frequently than monthly during the period that such provider or supplier is so enrolled, the State conducts a check of any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act to determine whether the Secretary has terminated the participation of such provider or supplier under title XVIII, or whether any other State has terminated the participation of such provider or supplier under such other State's State plan under this title (or waiver of the plan), or such other State's State child health plan under title XXI (or waiver of the plan).''.

SEC. 44106. ADDITIONAL MEDICAID PROVIDER SCREENING REQUIREMENTS.

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

''(C) PROVIDER SCREENING AGAINST DEATH MASTER FILE.—Beginning January 1, 2028, as part of the enrollment (or reenrollment or revalidation of enrollment) of a provider or supplier under this title, and not less frequently than quarterly during the period that such provider or supplier is so enrolled, the State conducts a check of the Death Master File (as such term is defined in section 203(d) of the Bipartisan Budget Act of 2013) to determine whether such provider or supplier is deceased.''.

SEC. 44107. REMOVING GOOD FAITH WAIVER FOR PAYMENT REDUCTION RELATED TO CERTAIN ERRONEOUS EXCESS PAYMENTS UNDER MEDICAID.

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

(1) in subparagraph (B)—

(A) by striking ''The Secretary'' and inserting ''(i) Subject to clause (ii), the Secretary''; and

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

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

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

''(II) the sum of the erroneous excess payments for medical assistance described in subclauses (I) and (III) of subparagraph (D)(i) made for such fiscal year.'';

(2) in subparagraph (C), by striking ''he'' in each place it appears and inserting ''the Secretary'' in each such place; and

(3) in subparagraph (D)(i)—

(A) in subclause (I), by striking ''and'' at the end;

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

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

''(III) payments (other than payments described in subclause (I)) for items and services furnished to an eligible individual who is not eligible for medical assistance under the State plan (or a waiver of such plan) with respect to such items and services.''.

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

SEC. 44108. INCREASING FREQUENCY OF ELIGIBILITY REDETERMINATIONS FOR CERTAIN INDIVIDUALS.

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

''(L) FREQUENCY OF ELIGIBILITY REDETERMINATIONS FOR CERTAIN INDIVIDUALS.—Beginning on October 1, 2027, in the case of an individual enrolled under subsection (a)(10)(A)(i)(VIII), a State shall redetermine the eligibility of such individual for medical assistance under the State plan of such State (or a waiver of such plan) once every 6 months.''.

SEC. 44109. REVISING HOME EQUITY LIMIT FOR DETERMINING ELIGIBILITY FOR LONG-TERM CARE SERVICES UNDER THE MEDICAID PROGRAM.

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

(1) in subparagraph (B)—

(A) by striking ''A State'' and inserting ''(i) A State'';

(B) in clause (i), as inserted by subparagraph (A)—

(i) by striking '' '$500,000' '' and inserting ''the amount specified in subparagraph (A)''; and

(ii) by inserting '', in the case of an individual's home that is located on a lot that is zoned for agricultural use,'' after ''apply subparagraph (A)''; and

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

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

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

(2) in subparagraph (C)—

(A) by inserting ''(other than the amount specified in subparagraph (B)(ii) (relating to certain non-agricultural homes))'' after ''specified in this paragraph''; and

(B) by adding at the end the following new sentence: ''In the case that application of the preceding sentence would result in a dollar amount (other than the amount specified in subparagraph (B)(i) (relating to certain agricultural homes)) exceeding $1,000,000, such amount shall be deemed to be equal to $1,000,000.''.

(b) CLARIFICATION.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

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

''(C) This paragraph shall not be construed as permitting a State to determine the eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services without application of the limit under section 1917(f)(1).''; and

(2) in subsection (e)(14)(D)(iv)—

(A) by striking ''Subparagraphs'' and inserting

''(I) IN GENERAL.—Subparagraphs''; and

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

''(II) APPLICATION OF HOME EQUITY INTEREST LIMIT.—Section 1917(f) shall apply for purposes of determining the eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services.''.

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

SEC. 44110. PROHIBITING FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID AND CHIP FOR INDIVIDUALS WITHOUT VERIFIED CITIZENSHIP, NATIONALITY, OR SATISFACTORY IMMIGRATION STATUS.

(a) IN GENERAL.—

(1) MEDICAID.—Section 1903(i)(22) of the Social Security Act (42 U.S.C. 1396b(i)(22)) is amended—

(A) by adding ''and'' at the end;

(B) by striking ''to amounts'' and inserting ''to—

''(A) amounts''; and

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

''(B) in the case that the State elects under section 1902(a)(46)(C) to provide for making medical assistance available to an individual during—

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

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

''(iii) the period in which the individual is provided the reasonable opportunity to submit evidence indicating a satisfactory immigration status under section 1137(d)(4),

amounts expended for such medical assistance, unless the citizenship or nationality of such individual or the satisfactory immigration status

of such individual (as applicable) is verified by the end of such period;''.

(2) CHIP.—Section 2107(e)(1)(N) of the Social Security Act (42 U.S.C. 1397gg(e)(1)(N)) is amended by striking ''and (17)'' and inserting ''(17), and (22)''.

(b) ELIMINATING STATE REQUIREMENT TO PROVIDE MEDICAL ASSISTANCE DURING REASONABLE OPPORTUNITY PERIOD.—

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

(A) by striking ''under clauses (i) and (ii) of section 1137(d)(4)(A)'' and inserting ''under section 1137(d)(4)''; and

(B) by inserting '', except that the State shall not be required to make medical assistance available to such individual during the period in which such individual is provided such reasonable opportunity if the State has not elected the option under section 1902(a)(46)(C)'' before the period at the end.

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

(A) in paragraph (1)(B)(ii)—

(i) in subclause (II), by striking ''(and continues to provide the individual with medical assistance during such 90-day period)'' and inserting ''and, if the State has elected the option under subsection (a)(46)(C), continues to provide the individual with medical assistance during such 90-day period''; and

(ii) in subclause (III), by inserting '', or denies eligibility for medical assistance under this title for such individual, as applicable'' after ''under this title''; and

(B) in paragraph (2)(C)—

(i) by striking ''under clauses (i) and (ii) of section 1137(d)(4)(A)'' and inserting ''under section 1137(d)(4)''; and

(ii) by inserting '', except that the State shall not be required to make medical assistance available to such individual during the period in which such individual is provided such reasonable opportunity if the State has not elected the option under section 1902(a)(46)(C)'' before the period at the end.

(3) INDIVIDUALS WITH SATISFACTORY IMMIGRATION STATUS.—Section 1137(d)(4) of the Social Security Act (42 U.S.C. 1320b–7(d)(4)) is amended—

(A) in subparagraph (A)(ii), by inserting ''(except that such prohibition on delay, denial, reduction, or termination of eligibility for benefits under the Medicaid program under title XIX shall apply only if the State has elected the option under section 1902(a)(46)(C))'' after ''has been provided''; and

(B) in subparagraph (B)(ii), by inserting ''(except that such prohibition on delay, denial, reduction, or termination of eligibility for benefits under the Medicaid program under title XIX shall apply only if the State has elected the option under section 1902(a)(46)(C))'' after ''status''.

(c) OPTION TO CONTINUE PROVIDING MEDICAL ASSISTANCE DURING REASONABLE OPPORTUNITY PERIOD.—

(1) MEDICAID.—Section 1902(a)(46) of the Social Security Act (42 U.S.C. 1396a(a)(46)) is amended—

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

(B) in subparagraph (B)(ii), by adding ''and'' at the end; and

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

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

''(i) to an individual described in subparagraph (B) during the period in which such individual is provided the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under subsection (ee)(2)(C) or section 1903(x)(4), or during the 90-day period described in subsection (ee)(1)(B)(ii)(II); or

''(ii) to an individual who is not a citizen or national of the United States during the period in which such individual is provided the reasonable opportunity to submit evidence indicating a satisfactory immigration status under section 1137(d)(4);''.

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

by adding at the end the following new subparagraph:

''(C) OPTION TO CONTINUE PROVIDING CHILD HEALTH ASSISTANCE DURING REASONABLE OPPORTUNITY PERIOD.—Section 1902(a)(46)(C) shall apply to States under this title in the same manner as it applies to a State under title XIX.''.

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

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

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

(1) in subsection (y)—

(A) in paragraph (1)(E), by inserting ''(or, for calendar quarters beginning on or after October 1, 2027, in the case such State is a specified State with respect to such calendar quarter, 80 percent)'' after ''thereafter''; and

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

''(C) SPECIFIED STATE.—The term 'specified State' means, with respect to a quarter, a State that—

''(i) provides any form of financial assistance during such quarter, in whole or in part, whether or not made under a State plan (or waiver of such plan) under this title or under another program established by the State, and regardless of the source of funding for such assistance, to or on behalf of an alien who is not a qualified alien or otherwise lawfully residing in the United States for the purchasing of health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act) for an alien who is not a qualified alien or otherwise lawfully residing in the United States; or

''(ii) provides any form of comprehensive health benefits coverage during such quarter, whether or not under a State plan (or wavier of such plan) under this title or under another program established by the State, and regardless of the source of funding for such coverage, to an alien who

is not a qualified alien or otherwise lawfully residing in the United States.

''(D) IMMIGRATION TERMS.—

''(i) ALIEN.—The term 'alien' has the meaning given such term in section 101(a) of the Immigration and Nationality Act.

''(ii) QUALIFIED ALIEN.—The term 'qualified alien' has the meaning given such term in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, except that—

''(I) the reference to 'at the time the alien applies for, receives, or attempts to receive a Federal public benefit' in subsection (b) of such section shall be treated as a reference to 'at the time the alien is provided comprehensive health benefits coverage described in clause (ii) of section 1905(y)(C) of the Social Security Act or is provided with financial assistance described in clause (i) of such section, as applicable'; and

''(II) the references to '(in the opinion of the agency providing such

benefits)' in subsection (c) of such section shall be treated as references to '(in the opinion of the State in which such comprehensive health benefits coverage or such financial assistance is provided, as applicable)'.''; and

(2) in subsection (z)(2)—

(A) in subparagraph (A), by striking ''for such year'' and inserting ''for such quarter''; and

(B) in subparagraph (B)(i)—

(i) in the matter preceding subclause (I), by striking ''for a year'' and inserting ''for a calendar quarter in a year''; and

(ii) in subclause (II), by striking ''for the year'' and inserting ''for the quarter for the State''.

Subpart B—Preventing Wasteful Spending

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

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

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

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

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

(1) by striking ''him'' and inserting ''the individual'';

(2) by striking ''the third month'' and inserting ''the month'';

(3) by striking ''he'' and inserting ''the individual''; and

(4) by striking ''his'' and inserting ''the individual's''.

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

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

(1) in clause (iv), by striking ''and'' at the end;

(2) in clause (v), by striking the period and inserting ''; and''; and

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

''(vi) shall, in the case that the State elects to provide child health or pregnancy-related assistance to an individual for any period prior to the month in which the individual made application for such assistance (or application was made on behalf of the individual), provide that such assistance is not made available to such individual for items and services included under the State child health plan (or waiver of such plan) that are furnished before the month preceding the month in which such individual made application (or application was made on behalf of such individual) for such assistance.''.

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

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

SEC. 44123. ENSURING ACCURATE PAYMENTS TO PHARMACIES UNDER MEDICAID.

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

(1) in paragraph (1)(A)—

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

(B) by striking ''and'' after the semicolon at the end of clause (i) and all that precedes it through ''(1)'' and inserting the following:

''(1) DETERMINING PHARMACY ACTUAL ACQUISITION COSTS.—The Secretary shall conduct a survey of retail community pharmacy drug prices and applicable non-retail pharmacy drug prices to determine national average drug acquisition cost benchmarks (as such term is defined by the Secretary) as follows:

''(A) USE OF VENDOR.—The Secretary may contract services for—

''(i) with respect to retail community pharmacies, the determination of retail survey prices of the national average drug

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

''(ii) with respect to applicable non-retail pharmacies—

''(I) the determination of survey prices, separate from the survey prices described in clause (i), of the non-retail national average drug acquisition cost for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts, rebates, and other price concessions (to the extent any information with respect to such discounts, rebates, and other price concessions is available) based on a monthly survey of such pharmacies; and

''(II) at the discretion of the Secretary, for each type of applicable non-retail pharmacy, the determination of survey prices, separate from the survey prices described in clause (i) or subclause (I) of this clause, of the national average drug acquisition cost for such type of pharmacy for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts, rebates, and other price concessions (to the extent any information with respect to such discounts, rebates, and other price concessions is available) based on a monthly survey of such pharmacies; and'';

(2) in subparagraph (B) of paragraph (1), by striking ''subparagraph (A)(ii)'' and inserting ''subparagraph (A)(iii)'';

(3) in subparagraph (D) of paragraph (1), by striking clauses (ii) and (iii) and inserting the following:

''(ii) The vendor must update the Secretary no less often than monthly on the survey prices for covered outpatient drugs.

''(iii) The vendor must differentiate, in collecting and reporting survey data, for all cost information collected, whether a pharmacy is a retail community pharmacy or an applicable non-retail pharmacy, including whether such pharmacy is an affiliate (as defined in subsection (k)(14)), and, in the case of an applicable non-retail pharmacy, which type of applicable non-retail pharmacy it is using the relevant pharmacy type indicators included in the guidance required by subsection (d)(2) of section 44123 of the Act titled 'An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14'.'';

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

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

ment, administrative fee, discount, rebate, or other price concession related to the dispensing of covered outpatient drugs to individuals receiving benefits under this title, regardless of whether such payment, reimbursement, administrative fee, discount, rebate, or other price concession is received from the State or a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D)) directly or from a pharmacy benefit manager or another entity that has a contract with the State or a managed care entity or other specified entity (as so defined), shall respond to surveys conducted under this paragraph.

''(G) SURVEY INFORMATION.—Information on national drug acquisition prices obtained under this paragraph shall be made publicly available in a form and manner to be determined by the Secretary and shall include at least the following:

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

''(ii) The sampling methodology and number of pharmacies sampled monthly.

''(iii) Information on price concessions to pharmacies, including discounts, rebates, and other price concessions, to the extent that such information may be publicly released and has been collected by the Secretary as part of the survey.

''(H) PENALTIES.—

''(i) IN GENERAL.—Subject to clauses (ii), (iii), and (iv), the Secretary shall enforce the provisions of this paragraph with respect to a pharmacy through the establishment of civil money penalties applicable to a retail community pharmacy or an applicable non-retail pharmacy.

''(ii) BASIS FOR PENALTIES.—The Secretary shall impose a civil money penalty established under this subparagraph on a retail community pharmacy or applicable non-retail pharmacy if—

''(I) the retail pharmacy or applicable non-retail pharmacy refuses or otherwise fails to respond to a request for information about prices in con-

nection with a survey under this subsection;

''(II) knowingly provides false information in response to such a survey; or

''(III) otherwise fails to comply with the requirements established under this paragraph.

''(iii) PARAMETERS FOR PENALTIES.—

''(I) IN GENERAL.—A civil money penalty established under this subparagraph may be assessed with respect to each violation, and with respect to each non-compliant retail community pharmacy (including a pharmacy that is part of a chain) or non-compliant applicable non-retail pharmacy (including a pharmacy that is part of a chain), in an amount not to exceed $100,000 for each such violation.

''(II) CONSIDERATIONS.—In determining the amount of a civil money penalty imposed under this subpara-

graph, the Secretary may consider the size, business structure, and type of pharmacy involved, as well as the type of violation and other relevant factors, as determined appropriate by the Secretary.

''(iv) RULE OF APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

''(I) LIMITATION ON USE OF APPLICABLE NON-RETAIL PHARMACY PRICING INFORMATION.—No State shall use pricing information reported by applicable non-retail pharmacies under subparagraph (A)(ii) to develop or inform payment methodologies for retail community pharmacies.'';

(5) in paragraph (2)—

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

entities (as such terms are defined in section 1903(m)(9)(D)),'' after ''under this title''; and

(B) in subparagraph (B), by inserting ''and the basis for such dispensing fees'' before the semicolon;

(6) by redesignating paragraph (4) as paragraph (5);

(7) by inserting after paragraph (3) the following new paragraph:

''(4) OVERSIGHT.—

''(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct periodic studies of the survey data reported under this subsection, as appropriate, including with respect to substantial variations in acquisition costs or other applicable costs, as well as with respect to how internal transfer prices and related party transactions may influence the costs reported by pharmacies that are affiliates (as defined in subsection (k)(13)) or are owned by, controlled by, or related under a common ownership structure with a wholesaler, distributor, or other entity that acquires covered outpatient drugs relative to costs reported by pharmacies not affiliated with

such entities. The Inspector General shall provide periodic updates to Congress on the results of such studies, as appropriate, in a manner that does not disclose trade secrets or other proprietary information.

''(B) APPROPRIATION.—There is appropriated to the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $5,000,000 for fiscal year 2026, to remain available until expended, to carry out this paragraph.''; and

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

(A) by inserting '', and $8,000,000 for each of fiscal years 2026 through 2033,'' after ''2010''; and

(B) by inserting ''Funds appropriated under this paragraph for each of fiscal years 2026 through 2033 shall remain available until expended.'' after the period.

(b) DEFINITIONS.—Section 1927(k) of the Social Security Act (42 U.S.C. 1396r–8(k)) is amended—

(1) in the matter preceding paragraph (1), by striking ''In the section'' and inserting ''In this section''; and

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

''(12) APPLICABLE NON-RETAIL PHARMACY.—The term 'applicable non-retail pharmacy' means a pharmacy that is licensed as a pharmacy by the State and that is not a retail community pharmacy, including a pharmacy that dispenses prescription medications to patients primarily through mail and specialty pharmacies. Such term does not include nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or low dispensing pharmacies (as defined by the Secretary).

''(13) AFFILIATE.—The term 'affiliate' means any entity that is owned by, controlled by, or related under a common ownership structure with a pharmacy benefit manager or a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D)).''.

(c) EFFECTIVE DATE.—

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

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

(2) DELAYED APPLICATION TO APPLICABLE NON-RETAIL PHARMACIES.—The pharmacy survey requirements established by the amendments to section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) made by this section shall apply to retail community pharmacies beginning on the effective date described in paragraph (1), but shall not apply to applicable non-retail pharmacies until the first day of the first quarter that begins on or after the date that is 18 months after the date of enactment of this section.

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

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

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

(2) INCLUSION OF PHARMACY TYPE INDICATORS.—The guidance published under paragraph (1) shall include pharmacy type indicators to distinguish between different types of applicable non-retail pharmacies, such as pharmacies that dispense prescriptions primarily through the mail and pharmacies that dispense prescriptions that require special handling or distribution. An applicable non-retail pharmacy may be identified through multiple pharmacy type indicators.

(e) IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

(2) NONAPPLICATION OF ADMINISTRATIVE PROCEDURE ACT.—Implementation of the amendments made by this section shall be exempt from the requirements of section 553 of title 5, United States Code.

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

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

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

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

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

''(6) TRANSPARENT PRESCRIPTION DRUG PASS-THROUGH PRICING REQUIRED.—

''(A) IN GENERAL.—A contract between the State and a pharmacy benefit manager (referred to in this paragraph as a 'PBM'), or a contract between the State and a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D) and collectively referred to in this paragraph as the 'entity') that includes provisions making the entity responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a

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

''(i) any payment made by the entity or the PBM (as applicable) for such a drug—

''(I) is limited to—

''(aa) ingredient cost; and

''(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State would pay if the State were making the payment directly in accordance with the State plan;

''(II) is passed through in its entirety (except as reduced under Federal or State laws and regulations in response to instances of waste, fraud, or abuse) by the entity or PBM to the pharmacy or provider that dispenses the drug; and

''(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of

title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the entity or the PBM, except that any payment by the entity or the PBM for the ingredient cost of such drug purchased by a covered entity (as defined in subsection (a)(5)(B)) may exceed the actual acquisition cost (as defined in 447.502 of title 42, Code of Federal Regulations, or any successor regulation) for such drug if—

''(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act;

''(bb) such payment for the ingredient cost of such drug does not exceed the maximum payment that would have been made by the entity or the PBM for the ingredient cost of such drug if such drug had not been pur-

chased by such covered entity; and

''(cc) such covered entity reports to the Secretary (in a form and manner specified by the Secretary), on an annual basis and with respect to payments for the ingredient costs of such drugs so purchased by such covered entity that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess;

''(ii) payment to the entity or the PBM (as applicable) for administrative services performed by the entity or PBM is limited to an administrative fee that reflects the fair market value (as defined by the Secretary) of such services;

''(iii) the entity or the PBM (as applicable) makes available to the State, and the Secretary upon request in a form and manner specified by the Secretary, all costs and payments related to covered outpatient drugs and accompanying administrative

services (as described in clause (ii)) incurred, received, or made by the entity or the PBM, broken down (as specified by the Secretary), to the extent such costs and payments are attributable to an individual covered outpatient drug, by each such drug, including any ingredient costs, professional dispensing fees, administrative fees (as described in clause (ii)), post-sale and post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees, and any and all other remuneration, as defined by the Secretary; and

''(iv) any form of spread pricing whereby any amount charged or claimed by the entity or the PBM (as applicable) that exceeds the amount paid to the pharmacies or providers on behalf of the State or entity, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments, as defined by the Secretary, (after allowing for an administrative fee as described in clause (ii)) is not

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

''(B) PUBLICATION OF INFORMATION.—The Secretary shall publish, not less frequently than on an annual basis and in a manner that does not disclose the identity of a particular covered entity or organization, information received by the Secretary pursuant to subparagraph (A)(iii)(III) that is broken out by State and by each of the following categories of covered entity within each such State:

''(i) Covered entities described in subparagraph (A) of section 340B(a)(4) of the Public Health Service Act.

''(ii) Covered entities described in subparagraphs (B) through (K) of such section.

''(iii) Covered entities described in subparagraph (L) of such section.

''(iv) Covered entities described in subparagraph (M) of such section.

''(v) Covered entities described in subparagraph (N) of such section.

''(vi) Covered entities described in subparagraph (O) of such section.''; and

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

''(14) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a State, managed care entity (as defined in section 1903(m)(9)(D)), or other specified entity (as so defined), or manages the prescription drug benefits provided by a State, managed care entity, or other specified entity, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the managing of appeals or grievances related to the prescription drug benefits, contracting with pharmacies, controlling the cost of covered outpatient drugs, or the provision of services related thereto. Such term includes any person or entity that acts as a price negotiator (with regard to payment amounts to pharmacies and providers for a covered outpatient drug or the net cost of the drug) or group purchaser on behalf of a State, managed care entity, or other specified entity or that carries out 1 or more of the

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

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

(1) in paragraph (2)(A)(xiii)—

(A) by striking ''and (III)'' and inserting ''(III)'';

(B) by inserting before the period at the end the following: '', and (IV) if the contract includes provisions making the entity responsible for coverage of covered outpatient drugs, the entity shall comply with the requirements of section 1927(e)(6)''; and

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

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

''(10) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by an other specified entity (as defined in paragraph (9)(D)(iii)) unless such services are provided in accordance with a contract between the State and such

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts between States and managed care entities, other specified entities, or pharmacy benefit managers that have an effective date beginning on or after the date that is 18 months after the date of enactment of this section.

(d) IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

(2) NONAPPLICATION OF ADMINISTRATIVE PROCEDURE ACT.—Implementation of the amendments made by this section shall be exempt from the requirements of section 553 of title 5, United States Code.

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

SEC. 44125. PROHIBITING FEDERAL MEDICAID AND CHIP FUNDING FOR GENDER TRANSITION PROCEDURES FOR MINORS.

(a) MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (26), by striking ''; or'' and inserting a semicolon;

(2) in paragraph (27), by striking the period at the end and inserting ''; or'';

(3) by inserting after paragraph (27) the following new paragraph:

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

(4) in the flush left matter at the end, by striking ''and (18),'' and inserting ''(18), and (28)''.

(b) CHIP.—Section 2107(e)(1)(N) of the Social Security Act (42 U.S.C. 1397gg(e)(1)(N)) is amended by striking ''and (17)'' and inserting ''(17), and (28)''.

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

''(kk) SPECIFIED GENDER TRANSITION PROCEDURES.—

''(1) IN GENERAL.—For purposes of section 1903(i)(28), except as provided in paragraph (2), the term 'specified gender transition procedure' means, with respect to an individual, any of the following when performed for the purpose of intentionally changing the body of such individual (including by disrupting the body's development, inhibiting its natural functions, or modifying its appearance) to no longer correspond to the individual's sex:

''(A) Performing any surgery, including—

''(i) castration;

''(ii) sterilization;

''(iii) orchiectomy;

''(iv) scrotoplasty;

''(v) vasectomy;

''(vi) tubal ligation;

''(vii) hysterectomy;

''(viii) oophorectomy;

''(ix) ovariectomy;

''(x) metoidioplasty;

''(xi) clitoroplasty;

‘‘(xii) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

‘‘(xiii) penectomy;

‘‘(xiv) phalloplasty;

‘‘(xv) vaginoplasty;

‘‘(xvi) vaginectomy;

‘‘(xvii) vulvoplasty;

‘‘(xviii) reduction thyrochondroplasty;

‘‘(xix) chondrolaryngoplasty;

‘‘(xx) mastectomy; and

‘‘(xxi) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other body features of an individual.

‘‘(B) Any placement of chest implants to create feminine breasts or any placement of erection or testicular prostheses.

‘‘(C) Any placement of fat or artificial implants in the gluteal region.

‘‘(D) Administering, prescribing, or dispensing to an individual medications, including—

‘‘(i) gonadotropin-releasing hormone (GnRH) analogues or other puberty-block-

ing drugs to stop or delay normal puberty; and

''(ii) testosterone, estrogen, or other androgens to an individual at doses that are supraphysiologic than would normally be produced endogenously in a healthy individual of the same age and sex.

''(2) EXCEPTION.—Paragraph (1) shall not apply to the following when furnished to an individual by a health care provider with the consent of such individual's parent or legal guardian:

''(A) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for an individual experiencing precocious puberty.

''(B) Medically necessary procedures or treatments to correct for—

''(i) a medically verifiable disorder of sex development, including—

''(I) 46,XX chromosomes with virilization;

''(II) 46,XY chromosomes with undervirilization; and

''(III) both ovarian and testicular tissue;

"(ii) sex chromosome structure, sex steroid hormone production, or sex hormone action, if determined to be abnormal by a physician through genetic or biochemical testing;

"(iii) infection, disease, injury, or disorder caused or exacerbated by a previous procedure described in paragraph (1), or a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function unless the procedure is performed, not including procedures performed for the alleviation of mental distress; or

"(iv) procedures to restore or reconstruct the body of the individual in order to correspond to the individual's sex after one or more previous procedures described in paragraph (1), which may include the removal of a pseudo phallus or breast augmentation.

"(3) SEX.—For purposes of paragraph (1), the term 'sex' means either male or female, as bio-

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

''(4) FEMALE.—For purposes of paragraph (3), the term 'female' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes eggs for fertilization.

''(5) MALE.—For purposes of paragraph (3), the term 'male' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.''.

SEC. 44126. FEDERAL PAYMENTS TO PROHIBITED ENTITIES.

(a) IN GENERAL.—No Federal funds that are considered direct spending and provided to carry out a State plan under title XIX of the Social Security Act or a waiver of such a plan shall be used to make payments to a prohibited entity for items and services furnished during the 10-year period beginning on the date of the enactment of this Act, including any payments made directly to the prohibited entity or under a contract or other arrangement between a State and a covered organization.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term ''prohibited entity'' means an entity, including its affiliates, subsidiaries, successors, and clinics—

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

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

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

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

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

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condi-

tion caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2024 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $1,000,000.

(2) DIRECT SPENDING.—The term ''direct spending'' has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

(3) COVERED ORGANIZATION.—The term ''covered organization'' means a managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act (42 U.S.C. 1396u–2(a)(1)(B))) or a prepaid inpatient health plan or prepaid ambulatory health plan (as such terms are defined in section

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

(4) STATE.—The term ''State'' has the meaning given such term in section 1101 of the Social Security Act (42 U.S.C. 1301).

Subpart C—Stopping Abusive Financing Practices

SEC. 44131. SUNSETTING ELIGIBILITY FOR INCREASED FMAP FOR NEW EXPANSION STATES.

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

(1) by striking ''which has not'' and inserting the following: ''which—

''(A) has not'';

(2) in subparagraph (A), as so inserted, by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(B) begins to expend amounts for all such individuals prior to January 1, 2026.''.

SEC. 44132. MORATORIUM ON NEW OR INCREASED PROVIDER TAXES.

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

(1) by striking ''or'' at the end;

(2) by striking ''if there'' and inserting ''if—

''(I) there''; and

(3) by adding at the end the following new subclauses:

''(II) the tax is first imposed by the State (or by a unit of local government in the State) on or after the date of the enactment of this subclause (other than such a tax for which the legislation or regulations providing for the imposition of such tax were enacted or adopted prior to such date of enactment); or

''(III) on or after the date of the enactment of this subclause, the State (or unit of local government) increases the amount or rate of tax imposed with respect to a class of health care items or services (or with respect to a type of provider or activity within such a class), or increases the base of the tax such that the tax is imposed with respect to a class of items or services (or with respect to a type of provider or activity within such a class) to which the tax did not previously apply, but only to the extent that such revenues are attributable to such increase and only if such increase was not pro-

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

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

(a) IN GENERAL.—Subject to subsection (b), the Secretary of Health and Human Services shall revise section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) such that, with respect to a payment described in such section made for a service furnished during a rating period beginning on or after the date of the enactment of this Act, the total payment rate for such service is limited to 100 percent of the specified total published Medicare payment rate.

(b) GRANDFATHERING CERTAIN PAYMENTS.—In the case of a payment described in section 438.6(c)(2)(iii) of title 42, Code of Federal Regulations (or a successor regulation) for which written prior approval was made before the date of the enactment of this Act for the rating period occurring as of such date of enactment, the revisions described in subsection (a) shall not apply to such payment for such rating period and for any subsequent rating period if the amount of such payment does not exceed the amount of such payment so approved.

(c) DEFINITIONS.—In this section:

(1) RATING PERIOD.—The term ''rating period'' has the meaning given such term in section 438.2 of title 42, Code of Federal Regulations (or a successor regulation).

(2) TOTAL PUBLISHED MEDICARE PAYMENT RATE.—The term ''total published Medicare payment rate'' means amounts calculated as payment for specific services that have been developed under part A or part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

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

SEC. 44134. REQUIREMENTS REGARDING WAIVER OF UNIFORM TAX REQUIREMENT FOR MEDICAID PROVIDER TAX.

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

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

''(iii) For purposes of clause (ii)(I), a tax is not considered to be generally redistributive if any of the following conditions apply:

''(I) Within a permissible class, the tax rate imposed on any taxpayer or tax rate group (as defined in paragraph (7)(J)) explicitly defined by its relatively lower volume or percentage of Medicaid taxable units (as defined in paragraph (7)(H)) is lower than the tax rate imposed on any other taxpayer or tax rate group explicitly defined by its relatively higher volume or percentage of Medicaid taxable units.

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

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

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

''(aa) based on payments or expenditures made under the program under this title without mentioning the term 'Medicaid' (or any similar term) to accomplish the same effect as described in subclause (I) or (II); or

''(bb) that closely approximates a taxpayer or tax rate group under the program under this title, to the same effect as described in subclause (I) or (II).''; and

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

''(H) The term 'Medicaid taxable unit' means a unit that is being taxed within a health care related tax that is applicable to the program under this title. Such term includes a unit that is used as the basis for—

''(i) payment under the program under this title (such as Medicaid bed days);

''(ii) Medicaid revenue;

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

''(iv) other units associated with the program under this title, as determined by the Secretary.

''(I) The term 'non-Medicaid taxable unit' means a unit that is being taxed within a health care related tax that is not applicable to the program under this title. Such term includes a unit that is used as the basis for—

''(i) payment by non-Medicaid payers (such as non-Medicaid bed days);

''(ii) non-Medicaid revenue;

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

''(iv) other units not associated with the program under this title, as determined by the Secretary.

''(J) The term 'tax rate group' means a group of entities contained within a permissible class of a health care related tax that are taxed at the same rate.''.

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

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

SEC. 44135. REQUIRING BUDGET NEUTRALITY FOR MEDICAID DEMONSTRATION PROJECTS UNDER SECTION 1115.

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

''(g) REQUIREMENT OF BUDGET NEUTRALITY FOR MEDICAID DEMONSTRATION PROJECTS.—

''(1) IN GENERAL.—Beginning on the date of the enactment of this subsection, the Secretary may not approve an application for (or renewal or amendment of) an experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX in a State (in this subsection referred to as a 'Medicaid demonstration project') unless the Secretary certifies that such project is not expected to result in an increase in the amount of Federal expenditures compared to the amount that such expenditures would otherwise be in the absence of such project.

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

an approval period for such project, less than the amount of such expenditures that would have otherwise been made in the absence of such project, the Secretary shall specify the methodology to be used with respect to any subsequent approval period for such project for purposes of taking the difference between such expenditures into account.''.

Subpart D—Increasing Personal Accountability

SEC. 44141. REQUIREMENT FOR STATES TO ESTABLISH MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS FOR CERTAIN INDIVIDUALS.

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

''(xx) COMMUNITY ENGAGEMENT REQUIREMENT FOR APPLICABLE INDIVIDUALS.—

''(1) IN GENERAL.—Beginning January 1, 2029, subject to the succeeding provisions of this subsection, a State shall provide, as a condition of eligibility for medical assistance for an applicable individual, that such individual is required to demonstrate community engagement under paragraph (2)—

''(A) in the case of an applicable individual who has filed an application for medical assistance under a State plan (or a waiver of such plan) under this title, for 1 or more (as specified by the State) consecutive months immediately preceding the month during which such individual applies for such medical assistance; and

''(B) in the case of an applicable individual enrolled and receiving medical assistance under a State plan (or under a waiver of such plan) under this title, for 1 or more (as specified by the State) months, whether or not consecutive—

''(i) during the period between such individual's most recent determination (or redetermination, as applicable) of eligibility and such individual's next regularly scheduled redetermination of eligibility (as verified by the State as part of such regularly scheduled redetermination of eligibility); or

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

with the requirement to demonstrate community engagement, during the period between the most recent and next such verification with respect to such individual.

''(2) COMMUNITY ENGAGEMENT COMPLIANCE DESCRIBED.—Subject to paragraph (3), an applicable individual demonstrates community engagement under this paragraph for a month if such individual meets 1 or more of the following conditions with respect to such month, as determined in accordance with criteria established by the Secretary through regulation:

''(A) The individual works not less than 80 hours.

''(B) The individual completes not less than 80 hours of community service.

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

''(D) The individual is enrolled in an educational program at least half-time.

''(E) The individual engages in any combination of the activities described in subparagraphs (A) through (D), for a total of not less than 80 hours.

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

''(3) EXCEPTIONS.—

''(A) MANDATORY EXCEPTION FOR CERTAIN INDIVIDUALS.—The State shall deem an applicable individual to have demonstrated community engagement under paragraph (2) for a month if—

''(i) for part or all of such month, the individual—

''(I) was a specified excluded individual (as defined in paragraph (9)(A)(ii)); or

''(II) was—

''(aa) under the age of 19;

''(bb) pregnant or entitled to postpartum medical assistance under paragraph (5) or (16) of subsection (e);

''(cc) entitled to, or enrolled for, benefits under part A of title

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

"(dd) described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); or

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

"(B) OPTIONAL EXCEPTION FOR SHORT-TERM HARDSHIP EVENTS.—

"(i) IN GENERAL.—The State plan (or waiver of such plan) may provide, in the case of an applicable individual who experiences a short-term hardship event during a month, that the State shall, upon the request of such individual under procedures established by the State (in accordance with standards specified by the Secretary), deem such individual to have demonstrated community engagement under paragraph (2) for such month.

"(ii) SHORT-TERM HARDSHIP EVENT DEFINED.—For purposes of this subparagraph, an applicable individual experiences

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

''(I) such individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services as the Secretary determines appropriate;

''(II) such individual resides in a county (or equivalent unit of local government)—

''(aa) in which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

''(bb) that, subject to a request from the State to the Secretary, made in such form, at such time, and containing such information as the Secretary may

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

''(AA) 8 percent; or

''(BB) 1.5 times the national unemployment rate; or

''(III) such individual experiences any other short-term hardship (as defined by the Secretary).

''(4) OPTION TO CONDUCT MORE FREQUENT COMPLIANCE VERIFICATIONS.—With respect to an applicable individual enrolled and receiving medical assistance under a State plan (or a waiver of such plan) under this title, the State shall verify (in accordance with procedures specified by the Secretary) that each such individual has met the requirement to demonstrate community engagement under paragraph (1) during each such individual's regularly scheduled redetermination of eligibility, except that a State may provide for such verifications more frequently.

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

under paragraph (1), the State shall, in accordance with standards established by the Secretary, establish processes and use reliable information available to the State (such as payroll data) without requiring, where possible, the applicable individual to submit additional information.

''(6) PROCEDURE IN THE CASE OF NONCOMPLIANCE.—

''(A) IN GENERAL.—If a State is unable to verify that an applicable individual has met the requirement to demonstrate community engagement under paragraph (1) (including, if applicable, by verifying that such individual was deemed to have demonstrated community engagement under paragraph (3)) the State shall (in accordance with standards specified by the Secretary)—

''(i) provide such individual with the notice of noncompliance described in subparagraph (B);

''(ii) (I) provide such individual with a period of 30 calendar days, beginning on the date on which such notice of noncompliance is received by the individual, to—

''(aa) make a satisfactory showing to the State of compliance with such requirement (including, if applicable, by showing that such individual was deemed to have demonstrated community engagement under paragraph (3)); or

''(bb) make a satisfactory showing to the State that such requirement does not apply to such individual on the basis that such individual does not meet the definition of applicable individual under paragraph (9)(A); and

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

''(iii) if no such satisfactory showing is made and the individual is not a specified excluded individual described in paragraph (9)(A)(ii), deny such individual's application for medical assistance under the State plan (or waiver of such plan) or, as

applicable, disenroll such individual from the plan (or waiver of such plan) not later than the end of the month following the month in which such 30-calendar-day period ends, provided that—

''(I) the State first determines whether, with respect to the individual, there is any other basis for eligibility for medical assistance under the State plan (or waiver of such plan) or for another insurance affordability program; and

''(II) the individual is provided written notice and granted an opportunity for a fair hearing in accordance with subsection (a)(3).

''(B) NOTICE.—The notice of noncompliance provided to an applicable individual under subparagraph (A)(i) shall include information (in accordance with standards specified by the Secretary) on—

''(i) how such individual may make a satisfactory showing of compliance with such requirement (as described in subparagraph (A)(ii)) or make a satisfactory show-

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

''(ii) how such individual may reapply for medical assistance under the State plan (or a waiver of such plan) under this title in the case that such individuals' application is denied or, as applicable, in the case that such individual is disenrolled from the plan (or waiver).

''(7) TREATMENT OF NONCOMPLIANT INDIVIDUALS IN RELATION TO CERTAIN OTHER PROVISIONS.—

''(A) CERTAIN FMAP INCREASES.—A State shall not be treated as not providing medical assistance to all individuals described in section 1902(a)(10)(A)(i)(VIII), or as not expending amounts for all such individuals under the State plan (or waiver of such plan), solely because such an individual is determined ineligible for medical assistance under the State plan (or waiver) on the basis of a failure to meet the re-

quirement to demonstrate community engagement under paragraph (1).

''(B) OTHER PROVISIONS.—For purposes of section 36B(c)(2)(B) of the Internal Revenue Code of 1986, an individual shall be deemed to be eligible for minimum essential coverage described in section 5000A(f)(1)(A)(ii) of such Code for a month if such individual would have been eligible for medical assistance under a State plan (or a waiver of such plan) under this title but for a failure to meet the requirement to demonstrate community engagement under paragraph (1).

''(8) OUTREACH.—

''(A) IN GENERAL.—In accordance with standards specified by the Secretary, beginning not later than October 1, 2028 (or, if earlier, the date that precedes January 1, 2029, by the number of months specified by the State under paragraph (1)(A) plus 3 months), and periodically thereafter, the State shall notify applicable individuals enrolled under a State plan (or waiver) under this title of the requirement to demonstrate community engagement under this

subsection. Such notice shall include information on—

''(i) how to comply with such requirement, including an explanation of the exceptions to such requirement under paragraph (3) and the definition of the term 'applicable individual' under paragraph (9)(A);

''(ii) the consequences of noncompliance with such requirement; and

''(iii) how to report to the State any change in the individual's status that could result in—

''(I) the applicability of an exception under paragraph (3) (or the end of the applicability of such an exception); or

''(II) the individual qualifying as a specified excluded individual under paragraph (9)(A)(ii).

''(B) FORM OF OUTREACH NOTICE.—A notice required under subparagraph (A) shall be delivered—

''(i) by regular mail (or, if elected by the individual, in an electronic format); and

''(ii) in 1 or more additional forms, which may include telephone, text message, an internet website, other commonly available electronic means, and such other forms as the Secretary determines appropriate.

''(9) DEFINITIONS.—In this subsection:

''(A) APPLICABLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'applicable individual' means an individual (other than a specified excluded individual (as defined in clause (ii)))—

''(I) who is eligible to enroll (or is enrolled) under the State plan under subsection (a)(10)(A)(i)(VIII); or

''(II) who—

''(aa) is otherwise eligible to enroll (or is enrolled) under a waiver of such plan that provides coverage that is equivalent to minimum essential coverage (as

described in section 5000A(f)(1)(A) of the Internal Revenue Code of 1986 and as determined in accordance with standards prescribed by the Secretary in regulations); and

''(bb) has attained the age of 19 and is under 65 years of age, is not pregnant, is not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is not otherwise eligible to enroll under such plan.

''(ii) SPECIFIED EXCLUDED INDIVIDUAL.—For purposes of clause (i), the term 'specified excluded individual' means an individual, as determined by the State (in accordance with standards specified by the Secretary)—

''(I) who is described in subsection (a)(10)(A)(i)(IX);

''(II) who—

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

''(bb) is a California Indian described in section 809(a) of such Act; or

''(cc) has otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary;

''(III) who is the parent, guardian, or caretaker relative of a disabled individual or a dependent child;

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

''(V) who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual—

‘‘(aa) who is blind or disabled (as defined in section 1614);

‘‘(bb) with a substance use disorder;

‘‘(cc) with a disabling mental disorder;

‘‘(dd) with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living;

‘‘(ee) with a serious and complex medical condition; or

‘‘(ff) subject to the approval of the Secretary, with any other medical condition identified by the State that is not otherwise identified under this clause;

‘‘(VI) who—

‘‘(aa) is in compliance with any requirements imposed by the State pursuant to section 407; or

‘‘(bb) is a member of a household that receives supple-

mental nutrition assistance program benefits under the Food and Nutrition Act of 2008 and is not exempt from a work requirement under such Act;

''(VII) who is participating in a drug addiction or alcoholic treatment and rehabilitation program (as defined in section 3(h) of the Food and Nutrition Act of 2008);

''(VIII) who is an inmate of a public institution; or

''(IX) who meets such other criteria as the Secretary determines appropriate.

''(B) EDUCATIONAL PROGRAM.—The term 'educational program' means—

''(i) an institution of higher education (as defined in section 101 of the Higher Education Act of 1965);

''(ii) a program of career and technical education (as defined in section 3 of the Carl D. Perkins Career and Technical Education Act of 2006); or

''(iii) any other educational program that meets such criteria as the Secretary determines appropriate.

''(C) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.

''(D) WORK PROGRAM.—The term 'work program' has the meaning given such term in section 6(o)(1) of the Food and Nutrition Act of 2008.

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

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) is amended by striking ''subject to subsection (k)'' and inserting ''subject to subsections (k) and (xx)''.

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

(d) GRANTS TO STATES.—

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

under paragraph (3), award to each State a grant equal to the amount specified in paragraph (2) for such State for purposes of establishing systems necessary to carry out the provisions of, and amendments made by, this section.

(2) AMOUNT SPECIFIED.—For purposes of paragraph (2), the amount specified in this paragraph is an amount that bears the same ratio to the amount appropriated under paragraph (3) as the number of applicable individuals (as defined in section 1902(xx) of the Social Security Act, as added by subsection (a)) residing in such State bears to the total number of such individuals residing in all States.

(3) FUNDING.—There are appropriated, out of any monies in the Treasury not otherwise appropriated, $100,000,000 for fiscal year 2026 for purposes of awarding grants under paragraph (1).

(4) DEFINITION.—In this subsection, the term ''State'' means 1 of the 50 States and the District of Columbia.

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

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

SEC. 44142. MODIFYING COST SHARING REQUIREMENTS FOR CERTAIN EXPANSION INDIVIDUALS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting ''(other than, beginning October 1, 2028, specified individuals (as defined in subsection (k)(3)))'' after ''individuals''; and

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

''(k) SPECIAL RULES FOR CERTAIN EXPANSION INDIVIDUALS.—

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

''(2) REQUIRED IMPOSITION OF COST SHARING.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsection (j), in the case of a

specified individual, the State plan shall, beginning October 1, 2028, provide for the imposition of such deductions, cost sharing, or similar charges determined appropriate by the State (in an amount greater than $0) with respect to medical assistance furnished to such an individual.

''(B) LIMITATIONS.—

''(i) EXCLUSION OF CERTAIN SERVICES.—In no case may a deduction, cost sharing, or similar charge be imposed under the State plan with respect to services described in any of subparagraphs (B) through (J) of subsection (a)(2) furnished to a specified individual.

''(ii) ITEM AND SERVICE LIMITATION.—

''(I) IN GENERAL.—Except as provided in subclause (II), in no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to an item or service furnished to a specified individual exceed $35.

''(II) SPECIAL RULES FOR PRESCRIPTION DRUGS.—In no case may a deduction, cost sharing, or similar charge imposed under the State plan with respect to a prescription drug furnished to a specified individual exceed the limit that would be applicable under paragraph (2)(A)(i) or (2)(B) of section 1916A(c) with respect to such drug and individual if such drug so furnished were subject to cost sharing under such section.

''(iii) MAXIMUM LIMIT ON COST SHARING.—The total aggregate amount of deductions, cost sharing, or similar charges imposed under the State plan for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

''(C) CASES OF NONPAYMENT.—Notwithstanding subsection (e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or

services to a specified individual entitled to medical assistance under this title for such care, items, or services, the payment of any deductions, cost sharing, or similar charges authorized to be imposed with respect to such care, items, or services. Nothing in this subparagraph shall be construed as preventing a provider from reducing or waiving the application of such deductions, cost sharing, or similar charges on a case-by-case basis.

''(3) SPECIFIED INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'specified individual' means an individual enrolled under section 1902(a)(10)(A)(i)(VIII) who has a family income (as determined in accordance with section 1902(e)(14)) that exceeds the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.''.

(b) CONFORMING AMENDMENTS.—

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

section 1916(k)) in accordance with paragraph (2) of such section'' after ''section 1916''.

(2) NONAPPLICABILITY OF ALTERNATIVE COST SHARING.—Section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended, in the second sentence, by striking ''or (j)'' and inserting ''(j), or (k)''.

PART 2—AFFORDABLE CARE ACT

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

(a) CHANGES TO ENROLLMENT PERIODS FOR ENROLLING IN EXCHANGES.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended—

(1) in subsection (c)(6)—

(A) by striking subparagraph (A);

(B) by striking ''The Secretary'' and inserting the following:

''(A) IN GENERAL.—The Secretary'';

(C) by redesignating subparagraphs (B) through (D) as clauses (i) through (iii), respectively, and adjusting the margins accordingly;

(D) in clause (i), as so redesignated, by striking ''periods, as determined by the Secretary for calendar years after the initial enroll-

ment period;'' and inserting the following: ''periods for plans offered in the individual market—

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

''(II) for enrollment for plan years beginning on or after January 1, 2026, beginning on November 1 and ending on December 15 of the preceding calendar year;'';

(E) in clause (ii), as so redesignated, by inserting ''subject to subparagraph (B),'' before ''special enrollment periods specified''; and

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

''(B) PROHIBITED SPECIAL ENROLLMENT PERIOD.—With respect to plan years beginning on or after January 1, 2026, the Secretary may not require an Exchange to provide for a special enrollment period for an individual on the basis of the relationship of the income of such individual to the poverty line, other than a special enrollment period based on a change in cir-

cumstances or the occurrence of a specific event.''; and

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

''(8) PROHIBITED ENROLLMENT PERIODS.—An Exchange may not provide for, with respect to enrollment for plan years beginning on or after January 1, 2026—

''(A) an annual open enrollment period other than the period described in subparagraph (A)(i) of subsection (c)(6); or

''(B) a special enrollment period described in subparagraph (B) of such subsection.

''(9) VERIFICATION OF ELIGIBILITY FOR SPECIAL ENROLLMENT PERIODS.—

''(A) IN GENERAL.—With respect to enrollment for plan years beginning on or after January 1, 2026, an Exchange shall verify that each individual seeking to enroll in a qualified health plan offered by the Exchange during a special enrollment period selected under subparagraph (B) is eligible to enroll during such special enrollment period prior to enrolling such individual in such plan.

''(B) SELECTED SPECIAL ENROLLMENT PERIODS.—For purposes of subparagraph (A), an Exchange shall select one or more special enrollment periods for a plan year with respect to which such Exchange shall conduct the verification required under subparagraph (A) such that the Exchange conducts such verification for not less than 75 percent of all individuals enrolling in a qualified health plan offered by the Exchange during any special enrollment period with respect to such plan year.''.

(b) VERIFYING INCOME FOR INDIVIDUALS ENROLLING IN A QUALIFIED HEALTH PLAN THROUGH AN EXCHANGE.—

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

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

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

''(C) REQUIRING VERIFICATION OF INCOME AND FAMILY SIZE WHEN TAX DATA IS UNAVAILABLE.—For plan years beginning on or

after January 1, 2026, for purposes of subparagraph (A), in the case that the Exchange requests data from the Secretary of the Treasury regarding an individual's household income and the Secretary of the Treasury does not return such data, such information may not be verified solely on the basis of the attestation of such individual with respect to such household income, and the Exchange shall take the actions described in subparagraph (A).

''(D) REQUIRING VERIFICATION OF INCOME IN THE CASE OF CERTAIN INCOME DISCREPANCIES.—

''(i) IN GENERAL.—Subject to clause (iii), for plan years beginning on or after January 1, 2026, for purposes of subparagraph (A), in the case that a specified income discrepancy described in clause (ii) of this subparagraph exists with respect to the information provided by an applicant under subsection (b)(3), the household income of such individual shall be treated as inconsistent with information in the records maintained by persons under subsection (c), or as not verified under sub-

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

''(ii) SPECIFIED INCOME DISCREPANCY.—For purposes of clause (i), a specified income discrepancy exists with respect to the information provided by an applicant under subsection (b)(3) if—

''(I) the applicant attests to a projected annual household income that would qualify such applicant to be an applicable taxpayer under section 36B(c)(1)(A) of the Internal Revenue Code of 1986 with respect to the taxable year involved;

''(II) the Exchange receives data from the Secretary of the Treasury or the Commissioner of Social Security, or other reliable, third party data, that indicates that the household income of such applicant is less than the household income that would qualify such applicant to be an applicable taxpayer under such section

36B(c)(1)(A) with respect to the taxable year involved;

''(III) such attested projected annual household income exceeds the income reflected in the data described in subclause (II) by a reasonable threshold established by the Exchange and approved by the Secretary (which shall be not less than 10 percent, and may also be a dollar amount); and

''(IV) the Exchange has not assessed or determined based on the data described in subclause (II) that the household income of the applicant meets the applicable income-based eligibility standard for the Medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act.

''(iii) EXCLUSION OF CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID.—This subparagraph shall not apply in the case of an applicant who is an alien lawfully present in the United States, who is

not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status.''.

(2) REQUIRING INDIVIDUALS ON WHOSE BEHALF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDITS ARE MADE TO FILE AND RECONCILE ON AN ANNUAL BASIS.—Section 1412(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(b)) is amended by adding at the end the following new paragraph:

''(3) ANNUAL REQUIREMENT TO FILE AND RECONCILE.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2026, in the case of an individual with respect to whom any advance payment of the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 was made under this section to the issuer of a qualified health plan for the relevant prior tax year, an advance determination of eligibility for such premium tax credit may not be made under this subsection with respect to such individual and such plan year if the Exchange determines, based on information pro-

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

''(i) has not filed an income tax return, as required under sections 6011 and 6012 of such Code (and implementing regulations), for the relevant prior tax year; or

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

''(B) RELEVANT PRIOR TAX YEAR.—For purposes of subparagraph (A), the term 'relevant prior tax year' means, with respect to the advance determination of eligibility made under this subsection with respect to an individual, the taxable year for which tax return data would be used for purposes of verifying the household income and family size of such individual (as described in section 1411(b)(3)(A)).

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

ments to file an income tax return for the relevant prior tax year and, as necessary, to reconcile the advance payment of the premium tax credit made with respect to such individual for such relevant prior tax year (as described in clauses (i) and (ii) of such subparagraph), the Secretary may make an initial advance determination of eligibility with respect to such individual and may delay for a reasonable period (as determined by the Secretary) any determination based on information provided by the Secretary of the Treasury that such individual has not fulfilled such requirements.

''(D) NOTICE.—If the Secretary determines that an individual did not meet the requirements described in subparagraph (A) with respect to the relevant prior tax year and notifies the Exchange of such determination, the Exchange shall comply with the notification requirement described in section 155.305(f)(4)(i) of title 45, Code of Federal Regulations (as in effect with respect to plan year 2025).''.

(3) REMOVING AUTOMATIC EXTENSION OF PERIOD TO RESOLVE INCOME INCONSISTENCIES.—The Secretary of Health and Human Services shall revise

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

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

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

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

(2) revise section 156.200(b)(3) of title 45, Code of Federal Regulations (or a successor regulation), to provide that, for plan years beginning on or after January 1, 2026, the requirement for a qualified health plan issuer described in such section is that the issuer ensures that each qualified health plan complies with benefit design standards, as defined in section 156.20 of such title; and

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

(d) UPDATING PREMIUM ADJUSTMENT PERCENTAGE METHODOLOGY.—Section 1302(c)(4) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(c)(4)) is amended—

(1) by striking ''For purposes'' and inserting:

''(A) IN GENERAL.—For purposes''; and

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

''(B) UPDATE TO METHODOLOGY.—For calendar years beginning with 2026, the premium adjustment percentage under this paragraph for such calendar year shall be determined consistent with the methodology published in the Federal Register on April 25, 2019 (84 Fed. Reg. 17537 through 17541).''.

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

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

after January 1, 2026, an Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18021 et seq.) may not reenroll an individual who was enrolled in a bronze level qualified health plan in a silver level qualified health plan (as such terms are defined in section 1301(a) and described in 1302(d) of such Act) unless otherwise permitted under section 155.335(j) of title 45, Code of Federal Regulations, as in effect on the day before the date of the enactment of this section.

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

(1) in subsection (a)(3), by inserting ", subject to subsection (c)(2)(C)," after "qualified health plans"; and

(2) in subsection (c)(2)—

(A) in subparagraph (A), by striking "The" and inserting "Subject to subparagraph (C), the"; and

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

"(C) REDUCTION IN ADVANCE PAYMENT FOR SPECIFIED REENROLLED INDIVIDUALS.—

''(i) IN GENERAL.—The amount of an advance payment made under subparagraph (A) to reduce the premium payable for a qualified health plan that provides coverage to a specified reenrolled individual for an applicable month shall be an amount equal to the amount that would otherwise be made under such subparagraph reduced by $5 (or such higher amount as the Secretary determines appropriate).

''(ii) DEFINITIONS.—In this subparagraph:

''(I) APPLICABLE MONTH.—The term 'applicable month' means, with respect to a specified reenrolled individual, any month during a plan year beginning on or after January 1, 2027 (or, in the case of an individual reenrolled in a qualified health plan by an Exchange established pursuant to section 1321(c), January 1, 2026) if, prior to the first day of such month, such individual has failed to confirm or update such information as

is necessary to redetermine the eligibility of such individual for such plan year pursuant to section 1411(f).

''(II) SPECIFIED REENROLLED INDIVIDUAL.—The term 'specified reenrolled individual' means an individual who is reenrolled in a qualified health plan and with respect to whom the advance payment made under subparagraph (A) would, without application of any reduction under this subparagraph, reduce the premium payable for a qualified health plan that provides coverage to such an individual to $0.''.

(h) PROHIBITING COVERAGE OF GENDER TRANSITION PROCEDURES AS AN ESSENTIAL HEALTH BENEFIT UNDER PLANS OFFERED BY EXCHANGES.—

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

''(C) GENDER TRANSITION PROCEDURES.—For plan years beginning on or after January 1, 2027, the essential health benefits

defined pursuant to paragraph (1) may not include items and services furnished for a gender transition procedure.''.

(2) GENDER TRANSITION PROCEDURE DEFINED.—Section 1304 of the Patient Protection and Affordable Care Act (42 U.S.C. 18024) is amended by adding at the end the following new subsection:

''(f) GENDER TRANSITION PROCEDURE.—

''(1) IN GENERAL.—In this title, except as provided in paragraph (2), the term 'gender transition procedure' means, with respect to an individual, any of the following when performed for the purpose of intentionally changing the body of such individual (including by disrupting the body's development, inhibiting its natural functions, or modifying its appearance) to no longer correspond to the individual's sex:

''(A) Performing any surgery, including—

''(i) castration;

''(ii) sterilization;

''(iii) orchiectomy;

''(iv) scrotoplasty;

''(v) vasectomy;

''(vi) tubal ligation;

''(vii) hysterectomy;

‘‘(viii) oophorectomy;

‘‘(ix) ovariectomy;

‘‘(x) metoidioplasty;

‘‘(xi) clitoroplasty;

‘‘(xii) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

‘‘(xiii) penectomy;

‘‘(xiv) phalloplasty;

‘‘(xv) vaginoplasty;

‘‘(xvi) vaginectomy;

‘‘(xvii) vulvoplasty;

‘‘(xviii) reduction thyrochondroplasty;

‘‘(xix) chondrolaryngoplasty;

‘‘(xx) mastectomy; and

‘‘(xxi) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other body features of an individual.

‘‘(B) Any placement of chest implants to create feminine breasts or any placement of erection or testicular prosetheses.

‘‘(C) Any placement of fat or artificial implants in the gluteal region.

''(D) Administering, prescribing, or dispensing to an individual medications, including—

''(i) gonadotropin-releasing hormone (GnRH) analogues or other puberty-blocking drugs to stop or delay normal puberty; and

''(ii) testosterone, estrogen, or other androgens to an individual at doses that are supraphysiologic than would normally be produced endogenously in a healthy individual of the same age and sex.

''(2) EXCEPTION.—Paragraph (1) shall not apply to the following:

''(A) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for an individual experiencing precocious puberty.

''(B) Medically necessary procedures or treatments to correct for—

''(i) a medically verifiable disorder of sex development, including—

''(I) 46,XX chromosomes with virilization;

''(II) 46,XY chromosomes with undervirilization; and

''(III) both ovarian and testicular tissue;

''(ii) sex chromosome structure, sex steroid hormone production, or sex hormone action, if determined to be abnormal by a physician through genetic or biochemical testing;

''(iii) infection, disease, injury, or disorder caused or exacerbated by a previous procedure described in paragraph (1), or a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the individual in imminent danger of death or impairment of a major bodily function unless the procedure is performed, not including procedures performed for the alleviation of mental distress; or

''(iv) procedures to restore or reconstruct the body of the individual in order to correspond to the individual's sex after one or more previous procedures described in paragraph (1), which may include the

removal of a pseudo phallus or breast augmentation.

''(3) SEX.—For purposes of this subsection, the term 'sex' means either male or female, as biologically determined and defined by subparagraph (A) and subparagraph (B).

''(A) FEMALE.—The term 'female' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes eggs for fertilization.

''(B) MALE.—The term 'male' means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.''.

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

(1) IN GENERAL.—Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)) is amended by adding at the end the following new paragraph:

''(4) CLARIFICATION OF LAWFUL PRESENCE.—In this title, the term 'alien lawfully present in the United States' does not include an alien granted deferred action under the Deferred Action for Childhood Arrivals process pursuant to the memorandum of the Department of Homeland Security entitled 'Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children' issued on June 15, 2012.''.

(2) COST-SHARING REDUCTIONS.—Section 1402(e)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(e)(2)) is amended by adding at the end the following new sentence: ''For purposes of this section, an individual shall not be treated as lawfully present if the individual is an alien granted deferred action under the Deferred Action for Childhood Arrivals process pursuant to the memorandum of the Department of Homeland Security entitled 'Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children' issued on June 15, 2012.''.

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

the previous sentence, an individual shall not be treated as lawfully present if the individual is an alien granted deferred action under the Deferred Action for Childhood Arrivals process pursuant to the memorandum of the Department of Homeland Security entitled 'Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children' issued on June 15, 2012.''.

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

(j) ENSURING APPROPRIATE APPLICATION OF GUARANTEED ISSUE REQUIREMENTS IN CASE OF NONPAYMENT OF PAST PREMIUMS.—

(1) IN GENERAL.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following new subsection:

''(e) NONPAYMENT OF PAST PREMIUMS.—

''(1) IN GENERAL.—A health insurance issuer offering individual health insurance coverage may, to the extent allowed under State law, deny such coverage in the case of an individual who owes any amount for premiums for individual health insurance coverage offered by such issuer (or by a health insurance issuer in the same controlled group (as de-

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

''(2) ATTRIBUTION OF INITIAL PREMIUM PAYMENT TO OWED AMOUNT.—A health insurance issuer offering individual health insurance coverage may, in the case of an individual described in paragraph (1) and to the extent allowed under State law, attribute the initial premium payment for such coverage applicable to such individual to the amount owed by such individual for premiums for individual health insurance coverage offered by such issuer (or by a health insurance issuer in the same controlled group as such issuer) in which such individual was previously enrolled.

''(3) CONTROLLED GROUP DEFINED.—For purposes of this subsection, the term 'controlled group' means a group of of two or more persons that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986.''.

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

PART 3—IMPROVING AMERICANS' ACCESS TO CARE

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

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

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

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

(2) in paragraph (3)(A)—

(A) by striking ''only one rare disease or condition'' and inserting ''one or more rare diseases or conditions''; and

(B) by striking ''such disease or condition'' and inserting ''one or more rare diseases or conditions (as such term is defined in section

526(a)(2) of the Federal Food, Drug, and Cosmetic Act)''.

(b) APPLICATION.—The amendments made by subsection (a) shall apply with respect to initial price applicability years (as defined in section 1191(b) of the Social Security Act (42 U.S.C. 1320f(b))) beginning on or after January 1, 2028.

SEC. 44302. STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS UNDER MEDICAID AND CHIP.

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

''(10) STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS.—

''(A) IN GENERAL.—The State—

''(i) adopts and implements a process to allow an eligible out-of-State provider to enroll under the State plan (or a waiver of such plan) to furnish items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without the imposition of screening or enrollment requirements by such State that exceed the minimum nec-

essary for such State to provide payment to an eligible out-of-State provider under such State plan (or a waiver of such plan), such as the provider's name and National Provider Identifier (and such other information specified by the Secretary); and

''(ii) provides that an eligible out-of-State provider that enrolls as a participating provider in the State plan (or a waiver of such plan) through such process shall be so enrolled for a 5-year period, unless the provider is terminated or excluded from participation during such period.

''(B) DEFINITIONS.—In this paragraph:

''(i) ELIGIBLE OUT-OF-STATE PROVIDER.—The term 'eligible out-of-State provider' means, with respect to a State, a provider—

''(I) that is located in any other State;

''(II) that—

''(aa) was determined by the Secretary to have a limited risk of fraud, waste, and abuse for purposes of determining the level

of screening to be conducted under section 1866(j)(2), has been so screened under such section 1866(j)(2), and is enrolled in the Medicare program under title XVIII; or

''(bb) was determined by the State agency administering or supervising the administration of the State plan (or a waiver of such plan) of such other State to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under paragraph (1) of this subsection, has been so screened under such paragraph (1), and is enrolled under such State plan (or a waiver of such plan); and

''(III) that has not been—

''(aa) excluded from participation in any Federal health care program pursuant to section 1128 or 1128A;

''(bb) excluded from participation in the State plan (or a waiver of such plan) pursuant to part 1002 of title 42, Code of Federal Regulations (or any successor regulation), or State law; or

''(cc) terminated from participating in a Federal health care program or the State plan (or a waiver of such plan) for a reason described in paragraph (8)(A).

''(ii) QUALIFYING INDIVIDUAL.—The term 'qualifying individual' means an individual under 21 years of age who is enrolled under the State plan (or waiver of such plan).

''(iii) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(77) of the Social Security Act (42 U.S.C. 1396a(a)(77)) is amended by inserting ''enrollment,'' after ''screening,''.

(2) The subsection heading for section 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is amended by inserting ''enrollment,'' after ''screening,''.

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

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

SEC. 44303. DELAYING DSH REDUCTIONS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i)—

(i) in the matter preceding subclause (I), by striking ''2026 through 2028'' and inserting ''2029 through 2031''; and

(ii) in subclause (II), by striking ''or period''; and

(B) in clause (ii), by striking ''2026 through 2028'' and inserting ''2029 through 2031''; and

(2) in paragraph (8), by striking ''2027'' and inserting ''2031''.

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

(1) in the header, by striking ''2025'' and inserting ''2028''; and

(2) by striking ''fiscal year 2025'' and inserting ''fiscal year 2028''.

SEC. 44304. MODIFYING UPDATE TO THE CONVERSION FACTOR UNDER THE PHYSICIAN FEE SCHEDULE UNDER THE MEDICARE PROGRAM.

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

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) in the first sentence, by striking ''and ending with 2025''; and

(ii) by striking the second sentence; and

(B) in subparagraph (D), by striking ''(or, beginning with 2026, applicable conversion factor)''; and

(2) by amending paragraph (20) to read as follows:

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

''(A) for 2026 is 75 percent of the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year; and

''(B) for 2027 and each subsequent year is 10 percent of the Secretary's estimate of the percentage increase in the MEI for the year.''.

SEC. 44305. MODERNIZING AND ENSURING PBM ACCOUNTABILITY.

(a) IN GENERAL.—

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

''(h) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2028:

''(1) AGREEMENTS WITH PHARMACY BENEFIT MANAGERS.—Each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan offered by such sponsor shall provide that any pharmacy benefit manager acting

on behalf of such sponsor has a written agreement with the PDP sponsor under which the pharmacy benefit manager, and any affiliates of such pharmacy benefit manager, as applicable, agree to meet the following requirements:

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

''(i) IN GENERAL.—The pharmacy benefit manager and any affiliate of such pharmacy benefit manager shall not derive any remuneration with respect to any services provided on behalf of any entity or individual, in connection with the utilization of covered part D drugs, from any such entity or individual other than bona fide service fees, subject to clauses (ii) and (iii).

''(ii) INCENTIVE PAYMENTS.—For the purposes of this subsection, an incentive payment (as determined by the Secretary) paid by a PDP sponsor to a pharmacy benefit manager (or an affiliate of such pharmacy benefit manager) that is performing services on behalf of such sponsor shall be deemed a 'bona fide service fee' (even if such payment does not otherwise

meet the definition of such term under paragraph (7)(B)) if such payment is a flat dollar amount, is consistent with fair market value (as specified by the Secretary), is related to services actually performed by the pharmacy benefit manager or affiliate of such pharmacy benefit manager, on behalf of the PDP sponsor making such payment, in connection with the utilization of covered part D drugs, and meets additional requirements, if any, as determined appropriate by the Secretary.

''(iii) CLARIFICATION ON REBATES AND DISCOUNTS USED TO LOWER COSTS FOR COVERED PART D DRUGS.—Rebates, discounts, and other price concessions received by a pharmacy benefit manager or an affiliate of a pharmacy benefit manager from manufacturers, even if such price concessions are calculated as a percentage of a drug's price, shall not be considered a violation of the requirements of clause (i) if they are fully passed through to a PDP sponsor and are compliant with all regulatory and subregulatory requirements 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-

priate by the Secretary. The Secretary, in consultation with the Office of the Inspector General, shall review whether remuneration under such arrangements is consistent with fair market value (as specified by the Secretary) through reviews and assessments of such remuneration, as determined appropriate.

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

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

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

''(II) attest, subject to any requirements determined appropriate by

the Secretary, that the pharmacy benefit manager has entered into a written agreement described in subclause (I) with any relevant affiliate of the pharmacy benefit manager.

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

''(i) define, interpret, and apply, in a fully transparent and consistent manner for purposes of calculating or otherwise evaluating pharmacy benefit manager performance against pricing guarantees or similar cost performance measurements related to rebates, discounts, price concessions, or net costs, terms such as—

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

''(II) 'brand name drug', in a manner consistent with the definition of the term under section 423.4 of

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

''(III) 'specialty drug';

''(IV) 'rebate'; and

''(V) 'discount';

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

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

''(C) PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Not later than July 1 of each year, beginning in 2028, the pharmacy benefit manager shall submit to the PDP sponsor, and to the Secretary, a report, in accordance with this subparagraph, and shall make such report avail-

able to such sponsor at no cost to such sponsor in a format specified by the Secretary under paragraph (5). Each such report shall include, with respect to such PDP sponsor and each plan offered by such sponsor, the following information with respect to the previous plan year:

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

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

''(bb) the number of plan enrollees for whom the drug was dispensed, the total number of prescription claims for the drug (including original prescriptions and refills, counted as separate claims), and the total number of dosage units of the drug dispensed;

''(cc) the number of prescription claims described in item (bb) by each type of dispensing

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

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

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

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

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

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

"(ii) the average pharmacy reimbursement amount paid by the plan for the drug in the aggregate and disaggregated by dispensing channel identified in item (cc);

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

"(kk) total manufacturer-derived revenue, inclusive of bona

fide service fees, attributable to the drug and retained by the pharmacy benefit manager and any affiliate of such pharmacy benefit manager.

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

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

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

that are included in the pharmacy network of such plan.

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

''(dd) The lowest total combined cost paid by the plan and plan enrollees, per dosage unit, per course of treatment, per 30-day supply, and per 90-day supply, for each drug that is available from any pharmacy included in the pharmacy network of such plan.

''(ee) The difference between the average acquisition cost of the affiliate, such as a pharmacy

or other entity that acquires prescription drugs, that initially acquires the drug and the amount reported under subclause (I)(jj) for each drug.

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

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

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

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

''(cc) Where a generic drug listed under item (aa) is on a formulary tier typically associated with higher cost-sharing than the listed drug, the estimated average cost-sharing that a beneficiary would have paid for a 30-

day supply of each of the generic drugs described in item (aa), had the plan provided coverage for such drugs on the same formulary tier as the listed drug.

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

''(ee) The number of currently marketed generic drugs approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act pursuant to an application that references such listed drug.

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

''(aa) A list of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health

Service Act pursuant to an application that refers to such reference product that are not covered by the plan, are covered on the same formulary tier or a formulary tier typically associated with higher cost-sharing than the reference product, or are subject to utilization management that the reference product is not subject to.

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

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

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

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

''(ee) The number of currently marketed biosimilar biological products licensed under section 351(k) of the Public Health Service Act, pursuant to an application that refers to such reference product.

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

''(VI) The total amount retained by the pharmacy benefit manager or an affiliate of such pharmacy benefit manager in revenue related to utilization of covered part D drugs under

that plan, inclusive of bona fide service fees.

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

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

''(IX) The following information:

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

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

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

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

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

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

''(I) IN GENERAL.—The pharmacy benefit manager shall, not later than 30 days after the finalization of any contract or agreement between

such pharmacy benefit manager or an affiliate of such pharmacy benefit manager and a drug manufacturer (or subsidiary, agent, or entity affiliated with such drug manufacturer) that makes rebates, discounts, payments, or other financial incentives related to one or more covered part D drugs or other prescription drugs, as applicable, of the manufacturer directly or indirectly contingent upon coverage, formulary placement, or utilization management conditions on any other covered part D drugs or other prescription drugs, as applicable, submit to the PDP sponsor a written explanation of such contract or agreement.

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

''(aa) include the manufacturer subject to the contract or agreement, all covered part D drugs and other prescription drugs, as applicable, subject to

the contract or agreement and the manufacturers of such drugs, and a high-level description of the terms of such contract or agreement and how such terms apply to such drugs; and

''(bb) be certified by the Chief Executive Officer, Chief Financial Officer, or General Counsel of such pharmacy benefit manager, or affiliate of such pharmacy benefit manager, as applicable, or an individual delegated with the authority to sign on behalf of one of these officers, who reports directly to the officer.

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

''(D) AUDIT RIGHTS.—

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

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

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

''(iv) TIMING.—The pharmacy benefit manager must provide information under

clause (iii) and other information, data, and records relevant to the audit to such auditor within 6 months of the initiation of the audit and respond to requests for additional information from such auditor within 30 days after the request for additional information.

''(v) INFORMATION FROM AFFILIATES.—The pharmacy benefit manager shall be responsible for providing to such auditor information required to be reported under subparagraph (C) or under clause (iii) of this subparagraph that is owned or held by an affiliate of such pharmacy benefit manager.

''(2) ENFORCEMENT.—

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

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

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

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

''(iii) require, in a written agreement with any such pharmacy benefit manager acting on behalf of such sponsor or affiliate of such pharmacy benefit manager, that such pharmacy benefit manager or affiliate be subject to punitive remedies for breach of contract for failure to comply with the requirements applicable under paragraph (1).

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

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

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

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

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

''(3) CERTIFICATION OF COMPLIANCE.—

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

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

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

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

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

''(5) STANDARD FORMATS.—

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

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

''(6) CONFIDENTIALITY.—

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

or a pharmacy under this subsection that is not otherwise publicly available or available for purchase shall not be disclosed by the Secretary or a PDP sponsor receiving the information, except that the Secretary may disclose the information for the following purposes:

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

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

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

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

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

''(vi) To the Inspector General of the Department of Health and Human Services in accordance with its authorities under the Inspector General Act of 1978

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

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

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

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

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

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

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

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

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

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

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

''(iii) coverage or formulary placement decisions or the volume or value of any referrals or business generated between the parties to the arrangement; or

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

''(C) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a PDP sponsor or prescription drug plan, or manages the prescription drug benefits provided by such sponsor or plan, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the proc-

essing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered part D drugs, or the provision of related services. Such term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a 'pharmacy benefit manager'.''.

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

''(F) REQUIREMENTS RELATING TO PHARMACY BENEFIT MANAGERS.—For plan years beginning on or after January 1, 2028, section 1860D–12(h).''.

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

(4) FUNDING.—

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

Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $113,000,000 for fiscal year 2025, to remain available until expended, to carry out this subsection.

(B) OIG.—In addition to amounts otherwise available, there is appropriated to the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $20,000,000 for fiscal year 2025, to remain available until expended, to carry out this subsection.

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

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

perts, to the extent available, with respect to the following:

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

(i) pharmacy benefit managers;

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

(iii) drug wholesalers;

(iv) pharmacies;

(v) manufacturers;

(vi) pharmacy services administrative organizations;

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

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

PD plans regarding pharmacy benefits; or

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

(viii) other service providers that contract with any of the entities described in clauses (i) through (vii) that may use price-related compensation and payment structures, such as rebate aggregators (or other entities that negotiate or process price concessions on behalf of pharmacy benefit managers, plan sponsors, or pharmacies).

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

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

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

scription drug price-related compensation structures, such as the potential for fees or other payments set as a percentage of a prescription drug's price to advantage formulary selection, distribution, or purchasing of prescription drugs with higher prices.

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

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

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

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

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

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

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

(i) a description of trends and patterns, including relevant averages, totals,

and other figures for the types of information submitted;

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

(iii) any recommendations the Commission determines appropriate.

(B) FINAL REPORT.—Not later than 2 years after the date on which the Commission submits the initial report under subparagraph (A), a report describing any changes with respect to the information described in subparagraph (A) over time, together with any recommendations the Commission determines appropriate.

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