

118TH CONGRESS  
2D SESSION

# H. R. 8261

To amend title XVIII of the Social Security Act to extend certain flexibilities and payment adjustments under the Medicare program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 7, 2024

Mr. SCHWEIKERT (for himself and Mr. THOMPSON of California) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to extend certain flexibilities and payment adjustments under the Medicare program, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Preserving Telehealth,  
5 Hospital, and Ambulance Access Act”.

1 **TITLE I—PRESERVING PA-**  
2 **TIENTS’ ACCESS TO CARE IN**  
3 **THE HOME**

4 **SEC. 101. EXTENSION OF CERTAIN TELEHEALTH FLEXIBILI-**  
5 **TIES.**

6 (a) REMOVING GEOGRAPHIC REQUIREMENTS AND  
7 EXPANDING ORIGINATING SITES FOR TELEHEALTH  
8 SERVICES.—Section 1834(m) of the Social Security Act  
9 (42 U.S.C. 1395m) is amended—

10 (1) in paragraph (2)(B)(iii), by striking “end-

11 ing December 31, 2024” and inserting “ending De-

12 cember 31, 2026”; and

13 (2) in paragraph (4)(C)(iii), by striking “ending

14 on December 31, 2024” and inserting “ending on

15 December 31, 2026”.

16 (b) EXPANDING PRACTITIONERS ELIGIBLE TO FUR-

17 NISH TELEHEALTH SERVICES.—Section 1834(m)(4)(E)

18 of the Social Security Act (42 U.S.C. 1395m(m)(4)(E))

19 is amended by striking “ending on December 31, 2024”

20 and inserting “ending on December 31, 2026”.

21 (c) EXTENDING TELEHEALTH SERVICES FOR FED-

22 ERALLY QUALIFIED HEALTH CENTERS AND RURAL

23 HEALTH CLINICS.—Section 1834(m)(8)(A) of the Social

24 Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by

1 striking “ending on December 31, 2024” and inserting  
2 “ending on December 31, 2026”.

3 (d) DELAYING THE IN-PERSON REQUIREMENTS  
4 UNDER MEDICARE FOR MENTAL HEALTH SERVICES  
5 FURNISHED THROUGH TELEHEALTH AND TELE-  
6 COMMUNICATIONS TECHNOLOGY.—

7 (1) DELAY IN REQUIREMENTS FOR MENTAL  
8 HEALTH SERVICES FURNISHED THROUGH TELE-  
9 HEALTH.—Section 1834(m)(7)(B)(i) of the Social  
10 Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is  
11 amended, in the matter preceding subclause (I), by  
12 striking “on or after” and all that follows through  
13 “described in section 1135(g)(1)(B))” and inserting  
14 “on or after January 1, 2027”.

15 (2) MENTAL HEALTH VISITS FURNISHED BY  
16 RURAL HEALTH CLINICS.—Section 1834(y)(2) of the  
17 Social Security Act (42 U.S.C. 1395m(y)(2)) is  
18 amended by striking “January 1, 2025” and all that  
19 follows through the period at the end and inserting  
20 “January 1, 2027.”.

21 (3) MENTAL HEALTH VISITS FURNISHED BY  
22 FEDERALLY QUALIFIED HEALTH CENTERS.—Section  
23 1834(o)(4)(B) of the Social Security Act (42 U.S.C.  
24 1395m(o)(4)(B)) is amended by striking “January

1 1, 2025” and all that follows through the period at  
2 the end and inserting “January 1, 2027.”.

3 (e) ALLOWING FOR THE FURNISHING OF AUDIO-  
4 ONLY TELEHEALTH SERVICES.—Section 1834(m)(9) of  
5 the Social Security Act (42 U.S.C. 1395m(m)(9)) is  
6 amended by striking “ending on December 31, 2024” and  
7 inserting “ending on December 31, 2026”.

8 (f) EXTENDING USE OF TELEHEALTH TO CONDUCT  
9 FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION  
10 OF ELIGIBILITY FOR HOSPICE CARE.—Section  
11 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C.  
12 1395f(a)(7)(D)(i)(II)) is amended—

13 (1) by striking “ending on December 31, 2024”  
14 and inserting “ending on December 31, 2026”; and

15 (2) by inserting “, except that this subclause  
16 shall not apply in the case of such an encounter with  
17 an individual occurring on or after January 1, 2025,  
18 if such individual is located in an area that is sub-  
19 ject to a moratorium on the enrollment of hospice  
20 programs under this title pursuant to section  
21 1866(j)(7), if such individual is receiving hospice  
22 care from a provider that is subject to enhanced  
23 oversight under this title pursuant to section  
24 1866(j)(3), or if such encounter is performed by a  
25 hospice physician or nurse practitioner who is not

1 enrolled under section 1866(j) and is not an opt-out  
2 physician or practitioner (as defined in section  
3 1802(b)(6)(D))” before the semicolon.

4 (g) PROGRAM INSTRUCTION AUTHORITY.—The Sec-  
5 retary of Health and Human Services may implement the  
6 amendments made by this section through program in-  
7 struction or otherwise.

8 **SEC. 102. GUIDANCE ON FURNISHING SERVICES VIA TELE-**  
9 **HEALTH TO INDIVIDUALS WITH LIMITED**  
10 **ENGLISH PROFICIENCY.**

11 (a) IN GENERAL.—Not later than 1 year after the  
12 date of the enactment of this section, the Secretary of  
13 Health and Human Services, in consultation with 1 or  
14 more entities from each of the categories described in  
15 paragraphs (1) through (7) of subsection (b), shall issue  
16 and disseminate, or update and revise as applicable, guid-  
17 ance for the entities described in such subsection on the  
18 following:

19 (1) Best practices on facilitating and inte-  
20 grating use of interpreters during a telemedicine ap-  
21 pointment.

22 (2) Best practices on providing accessible in-  
23 structions on how to access telecommunications sys-  
24 tems (as such term is used for purposes of section  
25 1834(m) of the Social Security Act (42 U.S.C.

1 1395m(m)) for individuals with limited English pro-  
2 ficiency.

3 (3) Best practices on improving access to dig-  
4 ital patient portals for individuals with limited  
5 English proficiency.

6 (4) Best practices on integrating the use of  
7 video platforms that enable multi-person video calls  
8 furnished via a telecommunications system for pur-  
9 poses of providing interpretation during a telemedi-  
10 cine appointment for an individual with limited  
11 English proficiency.

12 (5) Best practices for providing patient mate-  
13 rials, communications, and instructions in multiple  
14 languages, including text message appointment re-  
15 minders and prescription information.

16 (b) ENTITIES DESCRIBED.—For purposes of sub-  
17 section (a), an entity described in this subsection is an  
18 entity in 1 or more of the following categories:

19 (1) Health information technology service pro-  
20 viders, including—

21 (A) electronic medical record companies;

22 (B) remote patient monitoring companies;

23 and

24 (C) telehealth or mobile health vendors and  
25 companies.

- 1 (2) Health care providers, including—  
2 (A) physicians; and  
3 (B) hospitals.
- 4 (3) Health insurers.
- 5 (4) Language service companies.
- 6 (5) Interpreter or translator professional asso-  
7 ciations.
- 8 (6) Health and language services quality certifi-  
9 cation organizations.
- 10 (7) Patient and consumer advocates, including  
11 such advocates that work with individuals with lim-  
12 ited English proficiency.

13 **SEC. 103. ESTABLISHMENT OF MODIFIER FOR RECERTIFI-**  
14 **CATIONS OF HOSPICE CARE ELIGIBILITY**  
15 **CONDUCTED THROUGH TELEHEALTH.**

16 Section 1814(a)(7)(D)(i)(II) of the Social Security  
17 Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)), as amended by sec-  
18 tion 101(f), is further amended by inserting “, provided  
19 that, in the case of such an encounter occurring on or  
20 after the date that is 2 years after the date of the enact-  
21 ment of the ‘Preserving Telehealth, Hospital, and Ambu-  
22 lance Access Act’, such physician or nurse practitioner in-  
23 cludes in any claim for such encounter one or more modi-  
24 fiers or codes specified by the Secretary to indicate that

1 such encounter was furnished through telehealth” after  
2 “as determined appropriate by the Secretary”.

3 **SEC. 104. EXTENDING ACUTE HOSPITAL CARE AT HOME**  
4 **WAIVER FLEXIBILITIES.**

5 Section 1866G of the Social Security Act (42 U.S.C.  
6 1395cc-7) is amended—

7 (1) in subsection (a)(1), by striking “2024” and  
8 inserting “2029”; and

9 (2) in subsection (b)—

10 (A) in the header, by striking “STUDY AND  
11 REPORT” and inserting “STUDIES AND RE-  
12 PORTS”;

13 (B) in paragraph (1)—

14 (i) in the matter preceding subpara-  
15 graph (A), by striking “The Secretary”  
16 and inserting “Not later than September  
17 30, 2024, and again not later than Sep-  
18 tember 30, 2028, the Secretary”;

19 (ii) in clause (vi), by striking “and” at  
20 the end;

21 (iii) in clause (vii), by striking the pe-  
22 riod and inserting “; and”; and

23 (iv) by adding at the end the following  
24 new clause:



1           “(viii) in the case of the second study  
2           conducted under this paragraph, the qual-  
3           ity of care, outcomes, costs, quantity and  
4           intensity of services, and other relevant  
5           metrics between individuals who entered  
6           into the Acute Hospital Care at Home ini-  
7           tiative directly from an emergency depart-  
8           ment compared with individuals who en-  
9           tered into the Acute Hospital Care at  
10          Home initiative directly from an existing  
11          inpatient stay in a hospital.”; and

12          (C) in paragraph (2)—

13           (i) in the header, by striking “RE-  
14           PORT” and inserting “REPORTS”; and

15           (ii) by inserting “and again not later  
16           than September 30, 2028,” after “2024,”;  
17           and

18           (iii) by striking “on the study con-  
19           ducted under paragraph (1).” and insert-  
20           ing the following: “on—

21           “(A) with respect to the first report sub-  
22           mitted under this paragraph, the first study  
23           conducted under paragraph (1); and

1           “(B) with respect to the second report sub-  
2           mitted under this paragraph, the second study  
3           conducted under paragraph (1).”.

4 **SEC. 105. REPORT ON WEARABLE MEDICAL DEVICES.**

5           Not later than 18 months after the date of the enact-  
6           ment of this Act, the Comptroller General of the United  
7           States shall conduct a technology assessment of, and sub-  
8           mit to Congress a report on, the capabilities and limita-  
9           tions of wearable medical devices used to support clinical  
10          decision-making. Such report shall include a description  
11          of—

12           (1) the potential for such devices to accurately  
13          prescribe treatments;

14           (2) an examination of the benefits and chal-  
15          lenges of artificial intelligence to augment such ca-  
16          pabilities; and

17           (3) policy options to enhance the benefits and  
18          mitigate potential challenges of developing or using  
19          such devices.

20 **SEC. 106. ENHANCING CERTAIN PROGRAM INTEGRITY RE-**  
21 **QUIREMENTS FOR DME UNDER MEDICARE.**

22          (a) **DURABLE MEDICAL EQUIPMENT.**—Section  
23          1834(a) of the Social Security Act (42 U.S.C. 1395m(a))  
24          is amended by adding at the end the following new para-  
25          graph:

1           “(23) MASTER LIST INCLUSION AND CLAIM RE-  
2           VIEW FOR CERTAIN ITEMS.—

3           “(A) MASTER LIST INCLUSION.—Begin-  
4           ning January 1, 2026, for purposes of the Mas-  
5           ter List described in section 414.234(b) of title  
6           42, Code of Federal Regulations (or any suc-  
7           cessor regulation), an item for which payment  
8           may be made under this subsection shall be  
9           treated as having aberrant billing patterns (as  
10          such term is used for purposes of such section)  
11          if the Secretary determines that, without ex-  
12          planatory contributing factors (such as fur-  
13          nishing emergent care services), a substantial  
14          number of written orders for such items under  
15          this subsection are from an ordering physician  
16          or applicable practitioner with whom the indi-  
17          vidual involved does not have a prior relation-  
18          ship, as determined on the basis of prior pay-  
19          ment experience.

20          “(B) CLAIM REVIEW.—With respect to  
21          items furnished on or after January 1, 2026  
22          that are included on the Master List pursuant  
23          to subparagraph (A), if such an item is not sub-  
24          ject to a determination of coverage in advance  
25          pursuant to paragraph (15)(C), the Secretary

1           may conduct prepayment review of claims for  
2           payment for such item.”.

3           (b) REPORT ON IDENTIFYING CLINICAL DIAGNOSTIC  
4 LABORATORY TESTS AT HIGH RISK FOR FRAUD AND EF-  
5 FECTIVE MITIGATION MEASURES.—Not later than Janu-  
6 ary 1, 2026, the Inspector General of the Department of  
7 Health and Human Services shall submit to Congress a  
8 report assessing fraudulent claims for clinical diagnostic  
9 laboratory tests for which payment may be made under  
10 section 1834A of the Social Security Act (42 U.S.C.  
11 1395m–1) and effective tools for reducing such fraudulent  
12 claims. The report shall include—

13           (1) which, if any, clinical diagnostic laboratory  
14 tests are identified as being at high risk of fraudu-  
15 lent claims, and an analysis of the factors that con-  
16 tribute to such risk;

17           (2) with respect to a clinical diagnostic labora-  
18 tory test identified under subparagraph (A) as being  
19 at high risk of fraudulent claims—

20           (A) the amount payable under such section  
21 1834A with respect to such test;

22           (B) the number of such tests furnished to  
23 individuals enrolled under part B of title XVIII  
24 of the Social Security Act (42 U.S.C. 1395j et  
25 seq.);

1 (C) whether an order for such a test was  
2 more likely to come from a provider with whom  
3 the individual involved did not have a prior re-  
4 lationship, as determined on the basis of prior  
5 payment experience; and

6 (D) the frequency with which a claim for  
7 payment under such section 1834A included the  
8 payment modifier identified by code 59 or 91;  
9 and

10 (3) suggested strategies for reducing the num-  
11 ber of fraudulent claims made with respect to tests  
12 so identified as being at high risk, including—

13 (A) an analysis of whether the Centers for  
14 Medicare & Medicaid Services can detect aber-  
15 rant billing patterns with respect to such tests  
16 in a timely manner;

17 (B) any strategies for identifying and mon-  
18 itoring the providers who are outliers with re-  
19 spect to the number of such tests that such pro-  
20 viders order; and

21 (C) targeted education efforts to mitigate  
22 improper billing for such tests.

1 **TITLE II—SUSTAINING ACCESS**  
2 **TO HOSPITAL AND EMER-**  
3 **GENCY SERVICES**

4 **SEC. 201. EXTENSION OF INCREASED INPATIENT HOSPITAL**  
5 **PAYMENT ADJUSTMENT FOR CERTAIN LOW-**  
6 **VOLUME HOSPITALS.**

7 (a) IN GENERAL.—Section 1886(d)(12) of the Social  
8 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

9 (1) in subparagraph (B), by striking “during  
10 the portion of fiscal year 2025 beginning on January  
11 1, 2025, and ending on September 30, 2025, and”;

12 (2) in subparagraph (C)(i)—

13 (A) in the matter preceding subclause  
14 (I)—

15 (i) by striking “or portion of a fiscal  
16 year”; and

17 (ii) by striking “2024 and the portion  
18 of fiscal year 2025 beginning on October 1,  
19 2024, and ending on December 31, 2024”  
20 and inserting “2025”;

21 (B) in subclause (III), by striking “2024  
22 and the portion of fiscal year 2025 beginning  
23 on October 1, 2024, and ending on December  
24 31, 2024” and inserting “2025”; and

1 (C) in subclause (IV), by striking “the por-  
2 tion of fiscal year 2025 beginning on January  
3 1, 2025, and ending on September 30, 2025,  
4 and”; and

5 (3) in subparagraph (D)—

6 (A) in the matter preceding clause (i), by  
7 striking “2024 or during the portion of fiscal  
8 year 2025 beginning on October 1, 2024, and  
9 ending on December 31, 2024” and inserting  
10 “2025”; and

11 (B) in clause (ii), by striking “ 2024 and  
12 the portion of fiscal year 2025 beginning on Oc-  
13 tober 1, 2024, and ending on December 31,  
14 2024” and inserting “2025”.

15 (b) IMPLEMENTATION.—Notwithstanding any other  
16 provision of law, the Secretary of Health and Human  
17 Services may implement the provisions of, including the  
18 amendments made by, this section by program instruction  
19 or otherwise.

20 **SEC. 202. EXTENSION OF THE MEDICARE-DEPENDENT HOS-**  
21 **PITAL PROGRAM.**

22 (a) IN GENERAL.—Section 1886(d)(5)(G) of the So-  
23 cial Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amend-  
24 ed—

1 (1) in clause (i), by striking “January 1, 2025”  
2 and inserting “October 1, 2025”; and

3 (2) in clause (ii)(II), by striking “January 1,  
4 2025” and inserting “October 1, 2025”.

5 (b) CONFORMING AMENDMENTS.—

6 (1) EXTENSION OF TARGET AMOUNT.—Section  
7 1886(b)(3)(D) of the Social Security Act (42 U.S.C.  
8 1395ww(b)(3)(D)) is amended—

9 (A) in the matter preceding clause (i), by  
10 striking “January 1, 2025” and inserting “Oc-  
11 tober 1, 2025”; and

12 (B) in clause (iv), by striking “2024 and  
13 the portion of fiscal year 2025 beginning on Oc-  
14 tober 1, 2024, and ending on December 31,  
15 2024” and inserting “2025”.

16 (2) PERMITTING HOSPITALS TO DECLINE RE-  
17 CLASSIFICATION.—Section 13501(e)(2) of the Omni-  
18 bus Budget Reconciliation Act of 1993 (42 U.S.C.  
19 1395ww note) is amended by striking “2024, or the  
20 portion of fiscal year 2025 beginning on October 1,  
21 2024, and ending on December 31, 2024” and in-  
22 serting “2025”.



1 **SEC. 203. EXTENSION OF ADD-ON PAYMENTS FOR AMBU-**  
2 **LANCE SERVICES.**

3 (a) IN GENERAL.—Section 1834(l) of the Social Se-  
4 curity Act (42 U.S.C. 1395m(l)) is amended—

5 (1) in paragraph (12)(A), by striking “January  
6 1, 2025” and inserting “October 1, 2025”; and

7 (2) in paragraph (13), by striking “January 1,  
8 2025” in each place it appears and inserting “Octo-  
9 ber 1, 2025” in each such place.

10 (b) PROGRAM INSTRUCTION AUTHORITY.—Notwith-  
11 standing any other provision of law, the Secretary of  
12 Health and Human Services may implement the provisions  
13 of, including amendments made by, this section through  
14 program instruction or otherwise.

15 **TITLE III—OFFSETS**

16 **SEC. 301. REVISING PHASE-IN OF MEDICARE CLINICAL LAB-**  
17 **ORATORY TEST PAYMENT CHANGES.**

18 (a) REVISED PHASE-IN OF REDUCTIONS FROM PRI-  
19 VATE PAYOR RATE IMPLEMENTATION.—Section  
20 1834A(b)(3) of the Social Security Act (42 U.S.C.  
21 1395m–1(b)(3)) is amended—

22 (1) in subparagraph (A), by striking “2027”  
23 and inserting “2028”; and

24 (2) in subparagraph (B)—

25 (A) in clause (ii), by striking “2024” and  
26 inserting “2025”; and

1 (B) in clause (iii), by striking “2025  
2 through 2027” and inserting “2026 through  
3 2028”.

4 (b) REVISED REPORTING PERIOD FOR REPORTING  
5 OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISH-  
6 MENT OF MEDICARE PAYMENT RATES.—Section  
7 1834A(a)(1)(B) of the Social Security Act (42 U.S.C.  
8 1395m–1(a)(1)(B)) is amended—

9 (1) in clause (i), by striking “2024” and insert-  
10 ing “2025”; and

11 (2) in clause (ii), by striking “2025” each place  
12 it appears and inserting “2026”.

13 (c) IMPLEMENTATION.—The Secretary of Health and  
14 Human Services may implement the amendments made by  
15 this section by program instruction or otherwise.

16 **SEC. 302. ARRANGEMENTS WITH PHARMACY BENEFIT MAN-**  
17 **AGERS WITH RESPECT TO PRESCRIPTION**  
18 **DRUG PLANS AND MA-PD PLANS.**

19 (a) IN GENERAL.—

20 (1) PRESCRIPTION DRUG PLANS.—Section  
21 1860D–12 of the Social Security Act (42 U.S.C.  
22 1395w–112) is amended by adding at the end the  
23 following new subsection:

1       “(h) REQUIREMENTS RELATING TO PHARMACY BEN-  
2 EFIT MANAGERS.—For plan years beginning on or after  
3 January 1, 2027:

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

14                       “(A) NO INCOME OTHER THAN BONA FIDE  
15 SERVICE FEES.—

16                               “(i) IN GENERAL.—The pharmacy  
17 benefit manager and any affiliate of such  
18 pharmacy benefit manager shall not derive  
19 any remuneration with respect to any serv-  
20 ices provided on behalf of any entity or in-  
21 dividual, in connection with the utilization  
22 of covered part D drugs, from any such en-  
23 tity or individual other than bona fide serv-  
24 ice fees, subject to clauses (ii) and (iii).

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

20           “(iii) CLARIFICATION ON REBATES  
21 AND DISCOUNTS USED TO LOWER COSTS  
22 FOR COVERED PART D DRUGS.—Rebates,  
23 discounts, and other price concessions re-  
24 ceived by a pharmacy benefit manager or  
25 an affiliate of a pharmacy benefit manager

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

14 “(iv) EVALUATION OF REMUNERATION  
15 ARRANGEMENTS.—Components of subsets  
16 of remuneration arrangements (such as  
17 fees or other forms of compensation paid  
18 to or retained by the pharmacy benefit  
19 manager or affiliate of such pharmacy ben-  
20 efit manager), as determined appropriate  
21 by the Secretary, between pharmacy ben-  
22 efit managers or affiliates of such phar-  
23 macy benefit managers, as applicable, and  
24 other entities involved in the dispensing or  
25 utilization of covered part D drugs (includ-

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

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

22                 “(vi) ADDITIONAL REQUIREMENTS.—  
23          The pharmacy benefit manager shall—

24                         “(I) enter into a written agree-  
25                         ment with any affiliate of such phar-

1 macy benefit manager, under which  
2 the affiliate shall identify and disgorge  
3 any remuneration described in clause  
4 (v) to the pharmacy benefit manager;  
5 and

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

13 “(B) TRANSPARENCY REGARDING GUARAN-  
14 TEES AND COST PERFORMANCE EVALUA-  
15 TIONS.—The pharmacy benefit manager shall—

16 “(i) define, interpret, and apply, in a  
17 fully transparent and consistent manner  
18 for purposes of calculating or otherwise  
19 evaluating pharmacy benefit manager per-  
20 formance against pricing guarantees or  
21 similar cost performance measurements re-  
22 lated to rebates, discounts, price conces-  
23 sions, or net costs, terms such as—

24 “(I) ‘generic drug’, in a manner  
25 consistent with the definition of the

1 term under section 423.4 of title 42,  
2 Code of Federal Regulations, or a suc-  
3 cessor regulation;

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

9 “(III) ‘specialty drug’;

10 “(IV) ‘rebate’; and

11 “(V) ‘discount’;

12 “(ii) identify any drugs, claims, or  
13 price concessions excluded from any pric-  
14 ing guarantee or other cost performance  
15 calculation or evaluation in a clear and  
16 consistent manner; and

17 “(iii) where a pricing guarantee or  
18 other cost performance measure is based  
19 on a pricing benchmark other than the  
20 wholesale acquisition cost (as defined in  
21 section 1847A(c)(6)(B)) of a drug, cal-  
22 culate and provide a wholesale acquisition  
23 cost-based equivalent to the pricing guar-  
24 antee or other cost performance measure  
25 in the written agreement.



1 “(C) PROVISION OF INFORMATION.—

2 “(i) IN GENERAL.—Not later than  
3 July 1 of each year, beginning in 2027, the  
4 pharmacy benefit manager shall submit to  
5 the PDP sponsor, and to the Secretary, a  
6 report, in accordance with this subpara-  
7 graph, and shall make such report avail-  
8 able to such sponsor at no cost to such  
9 sponsor in a format specified by the Sec-  
10 retary under paragraph (5). Each such re-  
11 port shall include, with respect to such  
12 PDP sponsor and each plan offered by  
13 such sponsor, the following information  
14 with respect to the previous plan year:

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

18 “(aa) the brand name, ge-  
19 neric or non-proprietary name,  
20 and National Drug Code;

21 “(bb) the number of plan  
22 enrollees for whom the drug was  
23 dispensed, the total number of  
24 prescription claims for the drug  
25 (including original prescriptions

1 and refills, counted as separate  
2 claims), and the total number of  
3 dosage units of the drug dis-  
4 pensed;

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

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

19 “(ee) the average wholesale  
20 price for the drug, listed as cost  
21 per day’s supply, cost per dosage  
22 unit, and cost per typical course  
23 of treatment (as applicable);

24 “(ff) the total out-of-pocket  
25 spending by plan enrollees on

1 such drug after application of  
2 any benefits under the plan, in-  
3 cluding plan enrollee spending  
4 through copayments, coinsurance,  
5 and deductibles;

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

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

20 “(ii) the average pharmacy  
21 reimbursement amount paid by  
22 the plan for the drug in the ag-  
23 gregate and disaggregated by dis-  
24 pensing channel identified in item  
25 (cc);

1           “(jj) the average National  
2 Average Drug Acquisition Cost  
3 (NADAC); and

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

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

17           “(aa) The percentage of  
18 total prescriptions that were dis-  
19 pensed by pharmacies that are an  
20 affiliate of the pharmacy benefit  
21 manager for each drug.

22           “(bb) The interquartile  
23 range of the total combined costs  
24 paid by the plan and plan enroll-  
25 ees, per dosage unit, per course

1 of treatment, per 30-day supply,  
2 and per 90-day supply for each  
3 drug dispensed by pharmacies  
4 that are not an affiliate of the  
5 pharmacy benefit manager and  
6 that are included in the phar-  
7 macy network of such plan.

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

19 “(dd) The lowest total com-  
20 bined cost paid by the plan and  
21 plan enrollees, per dosage unit,  
22 per course of treatment, per 30-  
23 day supply, and per 90-day sup-  
24 ply, for each drug that is avail-  
25 able from any pharmacy included

1 in the pharmacy network of such  
2 plan.

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

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

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

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

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

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

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

18           “(ee) The number of cur-  
19 rently marketed generic drugs  
20 approved under section 505(j) of  
21 the Federal Food, Drug, and  
22 Cosmetic Act pursuant to an ap-  
23 plication that references such  
24 listed drug.



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

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

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

24                   “(cc) Where a biosimilar bi-  
25                   ological product listed under item

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

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

18 “(ee) The number of cur-  
19 rently marketed biosimilar bio-  
20 logical products licensed under  
21 section 351(k) of the Public  
22 Health Service Act, pursuant to  
23 an application that refers to such  
24 reference product.

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

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

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

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

24           “(IX) The following information:

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

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

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

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

24           “(XI) A summary document sub-  
25 mitted in a standardized template de-

1                   veloped by the Secretary that includes  
2                   such information described in sub-  
3                   clauses (I) through (X).

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

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

1 to the PDP sponsor a written expla-  
2 nation of such contract or agreement.

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

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

17 “(bb) be certified by the  
18 Chief Executive Officer, Chief Fi-  
19 nancial Officer, or General Coun-  
20 sel of such pharmacy benefit  
21 manager, or affiliate of such  
22 pharmacy benefit manager, as  
23 applicable, or an individual dele-  
24 gated with the authority to sign  
25 on behalf of one of these officers,

1 who reports directly to the offi-  
2 cer.

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

10 “(D) AUDIT RIGHTS.—

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

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

24 “(iii) PROVISION OF INFORMATION.—  
25 The pharmacy benefit manager shall make

1 available to such auditor all records, data,  
2 contracts, and other information necessary  
3 to confirm the accuracy of information  
4 provided under subparagraph (C), subject  
5 to reasonable restrictions on how such in-  
6 formation must be reported to prevent re-  
7 disclosure of such information.

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

17 “(v) INFORMATION FROM AFFILI-  
18 ATES.—The pharmacy benefit manager  
19 shall be responsible for providing to such  
20 auditor information required to be reported  
21 under subparagraph (C) that is owned or  
22 held by an affiliate of such pharmacy ben-  
23 efit manager.

24 “(2) ENFORCEMENT.—



1           “(A) IN GENERAL.—Each PDP sponsor  
2 shall—

3           “(i) disgorge to the Secretary any  
4 amounts disgorged to the PDP sponsor by  
5 a pharmacy benefit manager under para-  
6 graph (1)(A)(v);

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

19           “(iii) require, in a written agreement  
20 with any such pharmacy benefit manager  
21 acting on behalf of such sponsor or affil-  
22 iate of such pharmacy benefit manager,  
23 that such pharmacy benefit manager or af-  
24 filiate be subject to punitive remedies for  
25 breach of contract for failure to comply

1 with the requirements applicable under  
2 paragraph (1).

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

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

15 “(i) retaliate against an individual or  
16 entity for reporting an alleged violation  
17 under subparagraph (B); or

18 “(ii) coerce, intimidate, threaten, or  
19 interfere with the ability of an individual  
20 or entity to report any such alleged viola-  
21 tions.

22 “(3) CERTIFICATION OF COMPLIANCE.—

23 “(A) IN GENERAL.—Each PDP sponsor  
24 shall furnish to the Secretary (in a time and  
25 manner specified by the Secretary) an annual

1 certification of compliance with this subsection,  
2 as well as such information as the Secretary de-  
3 termines necessary to carry out this subsection.

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

8 “(4) RULE OF CONSTRUCTION.—Nothing in  
9 this subsection shall be construed as prohibiting pay-  
10 ments related to reimbursement for ingredient costs  
11 to any entity that acquires prescription drugs, such  
12 as a pharmacy or wholesaler.

13 “(5) STANDARD FORMATS.—

14 “(A) IN GENERAL.—Not later than June  
15 1, 2026, the Secretary shall specify standard,  
16 machine-readable formats for pharmacy benefit  
17 managers to submit annual reports required  
18 under paragraph (1)(C)(i).

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

23 “(6) CONFIDENTIALITY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(A) AFFILIATE.—The term ‘affiliate’  
22 means any entity that is owned by, controlled  
23 by, or related under a common ownership struc-  
24 ture with a pharmacy benefit manager or PDP  
25 sponsor, or that acts as a contractor or agent

1 to such pharmacy benefit manager or PDP  
2 sponsor, insofar as such contractor or agent  
3 performs any of the functions described under  
4 subparagraph (C).

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

17 “(i) drug price, such as wholesale ac-  
18 quisition cost or drug benchmark price  
19 (such as average wholesale price);

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

1                   “(iii) coverage or formulary placement  
2                   decisions or the volume or value of any re-  
3                   ferrals or business generated between the  
4                   parties to the arrangement; or

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

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

1 of whether such person or entity calls itself a  
2 ‘pharmacy benefit manager’.”.

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

7 “(F) REQUIREMENTS RELATING TO PHAR-  
8 MACY BENEFIT MANAGERS.—For plan years be-  
9 ginning on or after January 1, 2027, section  
10 1860D–12(h).”.

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

15 (4) FUNDING.—

16 (A) SECRETARY.—In addition to amounts  
17 otherwise available, there is appropriated to the  
18 Centers for Medicare & Medicaid Services Pro-  
19 gram Management Account, out of any money  
20 in the Treasury not otherwise appropriated,  
21 \$113,000,000 for fiscal year 2025, to remain  
22 available until expended, to carry out this sub-  
23 section.

24 (B) OIG.—In addition to amounts other-  
25 wise available, there is appropriated to the In-



1           spector General of the Department of Health  
2           and Human Services, out of any money in the  
3           Treasury not otherwise appropriated,  
4           \$20,000,000 for fiscal year 2025, to remain  
5           available until expended, to carry out this sub-  
6           section.

7           (b) GAO STUDY AND REPORT ON CERTAIN REPORT-  
8           ING REQUIREMENTS.—

9           (1) STUDY.—The Comptroller General of the  
10          United States (in this subsection referred to as the  
11          “Comptroller General”) shall conduct a study on  
12          Federal and State reporting requirements for health  
13          plans and pharmacy benefit managers related to the  
14          transparency of prescription drug costs and prices.  
15          Such study shall include an analysis of the following:

16                 (A) Federal statutory and regulatory re-  
17                 porting requirements for health plans and phar-  
18                 macy benefit managers related to prescription  
19                 drug costs and prices.

20                 (B) Selected States’ statutory and regu-  
21                 latory reporting requirements for health plans  
22                 and pharmacy benefit managers related to pre-  
23                 scription drug costs and prices.

24                 (C) The extent to which the statutory and  
25                 regulatory reporting requirements identified in

1           subparagraphs (A) and (B) overlap and con-  
2           flict.

3           (D) The resources required by health plans  
4           and pharmacy benefit managers to comply with  
5           the reporting requirements described in sub-  
6           paragraphs (A) and (B).

7           (E) Other items determined appropriate by  
8           the Comptroller General.

9           (2) REPORT.—Not later than 2 years after the  
10          date on which information is first required to be re-  
11          ported under section 1860D–12(h)(1)(C) of the So-  
12          cial Security Act, as added by subsection (a)(1), the  
13          Comptroller General shall submit to Congress a re-  
14          port containing the results of the study conducted  
15          under paragraph (1), together with recommenda-  
16          tions for legislation and administrative actions that  
17          would streamline and reduce the burden associated  
18          with the reporting requirements for health plans and  
19          pharmacy benefit managers described in paragraph  
20          (1).

21          (c) MEDPAC REPORTS ON AGREEMENTS WITH  
22          PHARMACY BENEFIT MANAGERS WITH RESPECT TO PRE-  
23          SCRIPTION DRUG PLANS AND MA–PD PLANS.—The  
24          Medicare Payment Advisory Commission shall submit to  
25          Congress the following reports:

1 (1) Not later than March 31, 2028, a report re-  
2 garding agreements with pharmacy benefit managers  
3 with respect to prescription drug plans and MA–PD  
4 plans. Such report shall include—

5 (A) a description of trends and patterns,  
6 including relevant averages, totals, and other  
7 figures for each of the types of information sub-  
8 mitted;

9 (B) an analysis of any differences in agree-  
10 ments and their effects on plan enrollee out-of-  
11 pocket spending and average pharmacy reim-  
12 bursement, and any other impacts; and

13 (C) any recommendations the Commission  
14 determines appropriate.

15 (2) Not later than March 31, 2030, a report de-  
16 scribing any changes with respect to the information  
17 described in paragraph (1) over time, together with  
18 any recommendations the Commission determines  
19 appropriate.

20 **SEC. 303. EXTENDING THE ADJUSTMENT TO THE CALCULA-**  
21 **TION OF HOSPICE CAP AMOUNTS UNDER THE**  
22 **MEDICARE PROGRAM.**

23 Section 1814(i)(2)(B) of the Social Security Act (42  
24 U.S.C. 1395f(i)(2)(B)) is amended—

1           (1) in clause (ii), by striking “2033” and in-  
2           serting “2034”; and

3           (2) in clause (iii), by striking “2033” and in-  
4           serting “2034”.

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