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(Original Signature of Member)

118TH CONGRESS
2D SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

Mr. SCHWEIKERT introduced the following bill; which was referred to the Committee on _____

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”.