Health for the Commonwealth through Affordability, Reform, and Expansion Act of 2026 or *Health CARE Act of 2026*

By Senator Mark R. Warner (VA)

Section 1 – Short Title and Table of Contents

Title I – Restoring Health Care and Lowering Costs

Sec. 101. Repeal of reconciliation health provisions. This section repeals most of the health title of the P.L. 119-21. Not repealed: Sec. 71202, temporary payment increase under the Medicare Physician Fee Schedule to account for exceptional circumstances; Sec. 71306, permanent extension of safe harbor for absence of deductible for telehealth services; and Sec. 71401, Rural Health Transformation Program. It rescinds unobligated implementation funding.

Sec. 102. Permanent extension of enhanced tax credit. This section makes permanent the Enhanced Premium Tax Credits. These amendments to the ACA were made first under the American Rescue Plan Act and the extended under the Inflation Reduction Act. Premium amounts would be capped on a sliding scale, starting at 0% of household income for families making 150% of the federal poverty line and increasing to a maximum of 8.5% of household income for all families, including those earning more than 400% of the federal poverty line.

Sec. 103. Promoting consumer outreach and education. This section restores funding of $100,000,000 annually to the federal exchange ACA navigator program, which ensures individuals have the education and guidance they need to enroll in affordable health care coverage.

Title II – Pathway to Universal Coverage

Sec. 201. Establishment of health plan. This section requires the Secretary of Health and Human Services to establish a low-cost public health care option.

Sec. 202. Availability of plan. This section ensures that individuals qualified to enroll in an existing ACA exchange plan and not otherwise eligible for employer sponsored health care coverage or traditional Medicare are permitted to enroll in the newly established public health care option.

Sec. 203. Affordability. This section requires the Secretary of Health and Human Services to ensure coverage options in such a plan are not more costly than comparable options on the ACA exchange.

Sec. 204. Participating providers. Under this section, the Secretary may require providers enrolled in Medicare and Medicaid to accept patients enrolled in the public health care option.

Sec. 205. Provider payment rates. This section requires the Secretary to establish competitive provider payment rates using the best information publicly available and data otherwise available to the Secretary. The Secretary shall give consideration to existing provider payment rates for commercial insurance plans and provider costs to deliver care, including the increased provider costs to deliver care in rural and medically underserved areas.

Sec. 206. No effect on Medicare benefits or Medicare trust funds. This section clarifies that such a plan shall have no impact on the Medicare Trust Fund or benefits for Medicare beneficiaries.

Title III – Strengthening Medicaid

Sec. 301. Increased FMAP for medical assistance to newly eligible individuals. This section would reinstate the enhanced federal match for states that choose to expand their Medicaid program and apply it retroactively, ensuring states that expanded late – like Virginia – get their fair share of federal payments.

Sec. 302. Supporting State Medicaid programs through economic downturns. This section increases the Medicaid Federal Medical Assistance Percentage (FMAP) for states and U.S. territories that experience economic downturns (i.e., high unemployment). This section would automatically connect the FMAP to state unemployment levels, so that federal aid would track with a state's economy. A state's FMAP would be calculated based on Local Area Unemployment Statistics collected by the Bureau of Labor Statistics and modified based on prospective and retrospective analysis.

Title IV – Lowering Drug Costs

Sec. 401. Expanding Medicare Drug price negotiation. This section:

- amends the Medicare Drug Price Negotiation Program to expand the number of negotiation-eligible drugs subject to negotiation. Under current law, in initial price applicability year 2029 and each subsequent year, 20 drugs are to be negotiated. This provision increases this to 30 drugs in 2030, 40 drugs in 2031, and 50 drugs in 2032 and each subsequent years.
- extends Medicare-negotiated prices to individuals enrolled under a group health plan or health insurance coverage offered in the group or individual market unless such individual's plan or issuer affirmatively elects not to participate under the program.

Sec. 402. Application of prescription drug inflation rebates to drugs furnished in the commercial market. This section extends the Medicare Part B inflation rebate and the Medicare inflation rebate for Covered Part D drugs to drugs furnished in the commercial market.

Sec. 403. Establishing an out-of-pocket limit on expenditures for prescription drugs under group health plans and group and individual health insurance coverage. This section

establishes prescription drug cost-sharing limitations for a group health plan or health insurance issuer offering group or individual health insurance coverage. For plan year 2028, the out-of-pocket limit is $2,000 for self-only coverage and $4,000 for coverage other than self-only coverage. For 2029 and subsequent years, this limit is increased by the premium adjustment percentage for that calendar year.

Sec. 404. Requirements with respect to cost-sharing for insulin products. This section extends to group health plans and health insurance issuers offering group or individual health insurance coverage the prohibition on imposing any cost-sharing in excess of $35 (or, if lower, the amount that is 25% of the negotiated price net of all price concessions) for a 30-day supply for selected insulin products beginning in 2028. In addition, no deductible can be applied to selected insulin products.

Title V – Ensuring Quality Health Insurance and Removing Barriers to Care

Sec. 501. Required exceptions process for medication step therapy protocols. This section requires a group health plan or a health insurance issuer offering coverage in connection with such a plan to offer a clear, timely exceptions process when step therapy is not in a patient's best interest and notes specific circumstances when an exception must be granted.

Sec. 502. Establishing requirements with respect to the use of prior authorization under Medicare advantage plans. This section reforms the use of prior authorization in Medicare Advantage by:

- requiring MA plans to (1) establish an electronic prior authorization program that meets specified standards; (2) annually submit to the CMS for publication specified prior authorization information, including the percentage of requests approved and the average response time; and (3) meet other standards, as set by the Centers for Medicare & Medicaid Services (CMS), relating to the quality and timeliness of prior authorization determinations.
- Directing CMS and the Office of the National Coordinator for Health Information Technology to publish a public report that analyzes the information received from MA plans, the feasibility of and a plan for implementing real-time decision-making with respect to prior authorization requests, and the impact on patient access of decisions that are made using artificial intelligence.

Sec. 503. Special enrollment period for provider terminations. This section creates a new special enrollment period for Medicare Advantage enrollees when their MA plan terminates their health care provider from their network.

Sec. 504. Providing coverage for hearing care under the Medicare program. This section adds hearing services to Medicare, including comprehensive evaluations and hearing aid coverage.

Title VI – Lowering the Cost of Care

Sec. 601. Strengthening hospital price transparency. This section:

- codifies and improves the current regulations requiring hospitals to post a machine-readable file (MRF), as well as a plain language description, of all negotiated rates and cash prices on a publicly available website;
- directs HHS and HHS OIG to develop a process to monitor compliance at least annually;
- requires hospitals to make public their ownership and investment interest entities;
- requires attestation from a hospital executive that all prices are accurate and complete;
- for hospitals out of compliance, subject to a corrective action plan, and which fail to comply with such plan:
    - subjects civil monetary penalties based on bed count. The Secretary shall not grant or extend a waiver of these penalties, except when a determination has been made that such penalties will disrupt patient care.
    - Prohibits such hospital from taking any extraordinary collections against a patient for debt incurred for the relevant services.

Sec. 602. Clinical diagnostic laboratory price transparency. This section requires applicable clinical laboratories to post a machine-readable file (MRF), as well as a plain language description, of all negotiated rates and cash prices for clinical diagnostic laboratory services, unless a hospital or ambulatory surgical center is already posting such laboratory's prices, with penalties for non-compliance. Clinical diagnostic laboratories will be required to make public information regarding the provider's ownership and investment interest entities. It requires attestation from an executive that all prices are accurate and complete. The Secretary shall not grant or extend a waiver of the penalties, except when a determination has been made that such penalties will disrupt patient care.

Sec. 603. Imaging services price transparency. This section requires each applicable imaging service provider to post a machine-readable file (MRF), as well as a plain language description, of all negotiated rates and cash prices, unless a hospital or ambulatory surgical center is already posting such provider's prices with penalties for non-compliance. Imaging service providers will be required to make public information regarding the provider's ownership and investment interest entities. It requires attestation from an executive that all prices are accurate and complete. The Secretary shall not grant or extend a waiver of the penalties, except when a determination has been made that such penalties will disrupt patient care.

Sec. 604. Ambulatory surgical center price transparency. This section requires each ambulatory surgical center to post a machine-readable file (MRF), as well as a plain language description, of all negotiated rates and cash prices, unless a hospital is already posting such center's prices, with penalties for non-compliance. Ambulatory surgical centers will be required to make public information regarding the provider's ownership and investment interest entities. It requires attestation from an executive that all prices are accurate and complete. The Secretary shall not grant or extend a waiver of the penalties, except when a determination has been made that such penalties will disrupt patient care.

Sec. 605. Strengthening health coverage transparency requirements. This section codifies and improves the Transparency in Coverage (TiC) provisions currently in regulation, with penalties for non-compliance. The section codifies the requirement that group health plans and

health insurance issuers offering coverage in the individual or group market provide enrollees, at the time of enrollment, detail information about the plan's benefits, in-network rates, cost-sharing, utilization management, and others. It also requires certain payment rates to be made public. Additionally, the section adds a requirement for attestation from a plan or third-party administrator (TPA) executive that all prices are accurate and complete. Health plans will be required to submit to HHS, applicable state authorities, and make public, information regarding the plan's ownership and investment interest entities.

Sec. 606. Increasing group health plan access to health data. This section clarifies that specified large employer and specific large group health plans must be given access to all claims and encounter data involved in paying claims from Covered Service Providers, such as a PBM, provider network, third-party administrator, or another entity acting as an intermediary, with penalties for non-compliance for entities that block the group health plan's access to this data. Covered Service Providers will be prohibited from limiting information regarding financial ties between Covered Service Providers and health care providers that file claims.

Sec. 607. Oversight of administrative service providers. This section requires health plan service providers working with specified large employers or large group health plans to provide quarterly disclosures regarding health care costs, reimbursement methodologies, rebates, fees, remuneration, alternative payment arrangements, and certain ownership relationships. Health insurance issuers offering individual or group coverage may elect to receive these disclosures.

Sec. 608. State preemption only in event of conflict. This section ensures federal law does not preempt any state laws regarding health care price transparency, except where it prevents the application of the requirements of the bill. This section does not preempt ERISA.

Sec. 609. Requirement for explanation of benefits. This section requires an explanation of benefits (EOB) to be provided by all group health plans or health insurance issuers in the group or individual market. An enrollee shall be held harmless for any amount billed that is substantially in excess of the estimate generated by the advanced explanation of benefits, unless they were for medically necessary items or services furnished based on unforeseen circumstances that could not have been reasonably anticipated by the provider or facility.

Sec. 610. Transparency in billing. This section requires health care providers or facilities billing for items or services to inform patients of their right to an itemized bill. The notice must also include information on the provider or facility's charity care policies. This section prohibits a provider or facility from billing or pursuing collections actions if they have not provided the above notice about how to request an itemized bill or if the billed amount is greater than the good faith estimate or the amount the facility posted in its price machine-readable file (there are exceptions for medically necessary care that was unforeseen or represent a patient-initiated change and could not reasonably have been anticipated).

Sec. 611. Technical amendments. Makes technical amendments to ensure the provisions can be implemented.

Sec. 612. Implementation and enforcement funding. Authorizes such sums as may be necessary for FY2027 and each subsequent fiscal year for DOL and HHS to implement and enforce the Health CARE Act and the amendments made by the Act.

Title VII – Reforming PBMs and Protecting Pharmacies

Sec. 701. Ensuring accurate payments to pharmacies under Medicaid. This section requires specified pharmacies participating in state Medicaid programs to respond to acquisition cost surveys and report drug acquisition costs, which would be used to calculate a drug's National Average Drug Acquisition Cost (NADAC) database. Specified pharmacies are retail community pharmacies, mail-order pharmacies, and specialty pharmacies.

Sec. 702. Preventing the use of abusive spread pricing in Medicaid. Prohibits in Medicaid the use of "spread pricing" by pharmacy benefits managers by requiring PBMs, paying on behalf of a State Medicaid program, to utilize a transparency prescription drug pass-through model under which payment is limited to the ingredient cost plus a professional dispensing fee, and is passed along in its entirety to the pharmacy or provider. PBMs would be paid an administrative service fee reflecting fair market value.