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Jan. 22, 2026

Congress Unveils Minibus Funding Bill with Health Extenders

Overview:

On Tuesday, Jan. 20, the House appropriators unveiled a three-part minibus spending package for Fiscal Year 2026. The package covers appropriations for the Department of Labor, Department of Health and Human Services (HHS), Department of Defense, Department of Transportation, and Department of Homeland Security. In addition to appropriations funding, the proposal includes several policy changes such as long-term extensions of expiring Medicare telehealth flexibilities and community health center funding, health care program reauthorizations, and significant pharmacy benefit manager (PBM) reform proposals extending to both Medicare and commercial plans. Notably, the package did not include major components of the Trump administration's recently announced "Great Healthcare Plan," such as increased federal contributions to individual health savings accounts or codification of Most-Favored-Nation drug pricing arrangements. The proposal also omits any extension of the Affordable Care Act's enhanced premium tax credits, which expired earlier this year and have led to increased premiums for millions of Americans. And while the bill's PBM proposals cover policies such as delinking PBM income from the price of drugs in Medicare, codification of Any Willing Pharmacy terms in PBM Medicare contracts and 100% rebate pass-through for commercial plans, a proposal to ban the practice of spread pricing in Medicaid PBM contracts was not included.

Bill Text:

https://docs.house.gov/billsthisweek/20260119/DEF%20LHHS%20HS%20THUD%20-%20Bill%20Text%20-%201-19-2026.PDF

Section Summary:

Appropriations

Health and Human Services Appropriations

Overall, the funding proposal offers $116.8 billion in discretionary FY 2026 appropriations for HHS. This includes notable funding increases for the National Institutes of Health ($48.7 billion), Substance Abuse and Mental Health Services Administration (SAMHSA) ($7.4 billion), Health Resources and Services Administration ($8.95 billion), Administration for Strategic Preparedness and Response ($3.69 billion) and Centers for Disease Control and Prevention ($9.1 billion). These proposed appropriations signify a stark contrast from the President's previous FY 2026 budget proposal, which called for billions in funding cuts to the aforementioned agencies.

Health Care Extenders

Medicaid

- Sec. 6101-6106 – Medicaid

Sections 6101 through 6106 of the minibus package pertain to the Medicaid program, including provisions to streamline enrollment for screened out-of-state providers (Sec. 6101), remove the eligibility age limit for working, disabled adults (Sec. 6102), protect the eligibility of military families who relocate (6103), and require states to conduct studies of maternity, labor, and delivery care costs (6104). Sections 6105 and 6106 both apply to the Disproportionate Share Hospital (DSH) program, eliminating allotment reductions for FY 2026 and 2027 (6105) and adjusting the definition of a 'Medicaid shortfall' to include Medicaid- and dual-eligible patient costs.

Medicare

- Sec. 6201-6215, Sec. 6217-6222 – Medicare Extenders & Flexibilities

The funding package includes extensions for several Medicare provisions that are either slated to expire at the end of the Fiscal Year or temporarily extended through an ongoing Continuing Resolution. This includes year-long extensions of the Medicare low-volume hospital payment adjustment (6201), Medicare-dependent Hospital program (6202), funding for Medicare hospice surveys (6207), and a 1.0 work geographic practice cost index floor (6208). Other sections are extended through the end of 2027, including add-on payments for ambulance services (6203), CMS quality measure selection (6205), low-income program funding outreach and assistance (6206), and certain COVID-19 pandemic-era telehealth flexibilities (6209). Additional provisions proposed under the Medicare title apply to additional telehealth flexibilities and the Acute Hospital Care at Home initiative (6210), enhanced program integrity requirements for durable medical equipment (DME), (6212). The bill enhances Medicare coverage for multi-cancer early detection screens (6221), external infusion pumps (6222), and prohibits cost-sharing on generic drugs for low-income subsidy (LIS) recipients (6219).

- Sec. 6216 – Report on Wearable Medical Devices

Sec. 6216 specifically tasks the Comptroller General of the United States with providing a technology assessment to Congress on the capabilities and limitations of wearable medical devices used to support clinical decision making. This report must be conducted within 18 months after the legislation is enacted.

- Sec. 6225 – Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department

This section includes "site-neutral" payment reforms for outpatient services and requires hospital outpatient departments located outside of a hospital's main campus to obtain and bill for services using a new unique National Provider Identifier number. Outpatient departments are required to attest their compliance to HHS and are subject to review by the OIG.

- Sec. 6226 – Revised Phase-In of Medicare Clinical Laboratory Test Payment Changes

This section delays a planned reduction in the Medicare Clinical Laboratory Fee Schedule for the remainder of 2026.

- Sec. 6227-6228 – Medicare Sequestration & Improvement Fund

Under current law, Medicare payments may be reduced by up to 2% through a federal budget enforcement tool known as sequestration. Sec. 6227 extends the current 2% reduction under sequestration through the first half of FY 2033. Sec. 6288 increases appropriations for the Medicare Improvement Fund from $1.403 billion to $2.062 billion.

Human Services

- Sec. 6301-6304 – Human Services Program Extenders

Sections 6301 through 6304 provide year-long funding extension for several programs administered by HHS, including the Sexual Risk Avoidance Education program (6301), Personal Responsibility Education program (6302), Funding-to-Family Health Information Centers program (6303), and Temporary Assistance for Needy Families program (6304). Each program would be funded through Dec. 31, 2026.

Public Health and Other Extenders

- Sec. 6401-6404, 6411 – Program Reauthorizations

These sections provide for year-long reauthorizations of several additional programs, including the Community Health Center Fund and National Health Service Corps (6401), Special Diabetes program (6402), National health Security program (6403), and implementation efforts around the No Suprises Act (6404). The Teaching Health Center Graduate Medical Education program would also receive a three-year reauthorization through FY 2029 (6401) while the World Trade Center Health program would receive an updated funding formula through FY 2040.

Public Health Programs

- Sec. 6501-6508 – Additional program reauthorizations

Other public health programs authorized or authorized by the proposed funding package include federal support for state-based maternal morality review committees through FY 2030 (6501), a two-year funding extension for NIH pediatric drug studies (6504), a reauthorization of sickle cell disease prevention and treatment programs (6505), a Lifespan Respite Care program reauthorization through FY 2030, and reauthorization of public health and prevention activities related to preterm birth through FY 2030 (6507). Section 6508 updates HHS' requirement to release best practices for suicide prevention among health care professionals and reauthorizes an additional suicide education and awareness program for healthcare professionals through FY 2030. Sections 6502 and 6503 apply to organ donors and transplant networks, authorizing the HHS Secretary to collect fees from members of the Organ Procurement and Transplantation network and prohibiting considerations of recipients' income when determining a donor's eligibility for qualified reimbursements.

Food and Drug Administration

- Sec. 6601-6605 – Mikaela Naylon Give Kids a Chance Act

Sections 6601 to 6605 under the FDA title cover pediatric disease and treatment research. These provisions would grant FDA the authority to require pediatric cancer trials for new drugs used to treat adult cancer, while also providing the agency with the authority to penalize companies not in compliance with pediatric study requirements (6601, 6602). Section 6603 requires the FDA to compile a report on Pediatric Research Act enforcement. Section 6604 extends the FDA priority review voucher program through FY 2029 to incentivize rare pediatric disease drug development. Section 6605 clarifies that the current orphan drug exclusivity policy applies to a drug's approved indication, rather than its broader designation.

- Sec. 6611 – Establishment of Abraham Accords Office

This section requires FDA to establish an office in an Abraham Accords nation, in order to facilitate multi-national collaboration. The Abraham Accords are a series of diplomatic agreements normalizing ties between Israel and other Arab nations, including the United Arab Emirates, Bahrain, Morocco, and Sudan.

- Sec. 6703 – Increasing Transparency in Generic Drug Applications

This section modifies the Federal Food, Drug, and Cosmetic Act to provide manufacturers with transparency into the generic drug application process. It specifically requires FDA, upon request, to share whether a prospective formulation is qualitatively and quantitatively the same as an existing reference drug. This includes data on whether the proposed formulation mirrors the same ingredients and same ingredient amounts as a reference drug. If such metrics differ, the FDA is required to notify manufacturers of the ingredients that differ and what ingredient amounts differ. The HHS Secretary may not rescind such determination of equivalency unless an application's formulation changes or an error was identified in the application process. These provisions come into effect immediately after enactment. Within one year of enactment, HHS must provide regulatory guidance on determining how a drug is qualified and quantified as equivalent.

PBM Reform Provisions

<u>Medicare</u>

- Sec. 6223 – Assuring Pharmacy Access and Choice for Medicare Beneficiaries

PBMs and plan sponsors contracted with Medicare must allow any pharmacy that meets standard contract terms to participate in the plan network in a policy known as "Any Willing Pharmacy (AWP)." By April 2027, HHS is required to establish "reasonable and relevant" Medicare Part D plan (PDP) contract terms and conditions for the purposes of facilitating AWP participation. To determine these terms and conditions, CMS must publish a public Request for Information (RFI) prior to April 2026 to understand PDP and network contracting practices, rebating and reimbursement strategies, and operational and administrative costs, among other metrics. The AWP provision of this bill also provided several policies relating to "essential retail pharmacies," which it defines as non-affiliate entities that are the only pharmacy within a certain range (10 miles for 'rural areas,' 2 miles for 'suburban,' and 1 mile for 'urban' areas). After Jan. 1, 2028, the bill requires HHS to publish reports every two years regarding drug dispensing, network participation, reimbursement, dispensing fee,

and incentive fee trends paid by plan sponsors to essential pharmacies, as well as a comparison of such trends between essential and non-essential pharmacies as defined under the bill. To assist with the generation of these reports, including an annual list of essential retail pharmacies, PDP and MA-PD sponsors must report to HHS annually on contracted affiliate pharmacies (starting in plan year 2028) and information on incentive payments and other fees paid to pharmacies. The AWP provision would require HHS to establish, by Jan. 1, 2028, a new avenue for pharmacies to report PBM contract violations once per plan year. PBMs and plan sponsors would be barred from restricting or preventing network pharmacies from submitting contract violations, as well as retaliation against those affiliates that do report. Sponsors subject to review under a contract violation allegation must provide contract materials to HHS, which will also develop a standardized template for pharmacies to submit allegations. Under this section, HHS may impose CMPs or intermediate sanctions on PBMs that violate reasonable and relevant contract terms. Two years after enactment, and every two years following, HHS would be required to publish a report on enforcement and oversight actions undertaken by the Department. The bill would also appropriate $188 million in FY 2026 for implementation.

- Sec. 6224 – Modernizing and Ensuring PBM Accountability

Sec. 6224 is comprised of the Modernizing and Ensuring PBM Accountability Act, a prior reform bill which includes delinking PBM income from a drug's price, increased reporting requirements, and full pass through of rebates to Part D and MA plan sponsors. This section specifically limits the income of PBMs contracted with PDP and MA-PD plans to bona fide service fees, including incentive payments. A PBM must pass 100% of any rebates, discounts, or other price concessions on to plan sponsors. This section grants the HHS Secretary and Office of the Inspector General (OIG) with the power to assess PBM remuneration agreements to determine if such agreements are reflective of fair market value.

PBMs contracted with Medicare PDPs would be required to set and maintain consistent definitions of the terms 'generic drug', 'brand name drug', 'specialty drug,' 'rebate', and 'discount,' and identify drugs and price concession excluded from pricing guarantees or cost performance measures, for the purpose of calculating PBM cost performance evaluations. By July 1 of each year, beginning in 2028, PBMs would be required to submit annual reports to the Medicare PDP plan sponsors and to HHS on drug dispensing and cost data generated from the previous plan year. The report would include a list of drugs dispensed along with the drug 's name, National Drug Code, number of enrollees and claims corresponding to the drug, dispensing channel, average wholesale price and acquisition cost, total out-of-pocket-spending by enrollees and total rebates paid by manufacturers, average pharmacy reimbursement, average NADAC, and total manufacturer-derived revenue retained by the PBM. The annual reports would also be required to include data on affiliate pharmacies such as a list of affiliates, the percentage of prescriptions dispensed and cost comparisons between affiliates and non-affiliates. In relation to brand drugs and biologics covered by the PBM, the reports must also contain a list of generics/biosimilars marketed but not covered, or covered at a higher tier, and justification for the placement of the brand drug/biologic over a generic/biosimilar. Additional required data points for these reports includes total gross spending on covered Part D drugs, total net spending on Part D covered drugs, and total revenue retained by PBMs and affiliates, alongside written justification for the use of benefit design strategies that favor affiliates, and a list of third-party entities (including brokers, consultants, and advisors) contracted by the PBM. These data points must all be compiled into a summary document based on a template to be provided by HHS. Within 30 days after a PBM and manufacturer enter into a contract, PBMs would also be required to compile written explanations of rebating, coverage, and utilization management strategies within such contracts. The explanations

must include a list of covered Part D drugs covered by the contract, a high-level overview of contract terms, and must be certified by a C-Suite executive of the PBM or affiliate. Plan sponsors would also receive enhanced auditing capabilities under this bill, including the ability to audit PBMs annually upon request. PBMs would be required to compile and deliver the required information within six months of the audit request and must respond to requests for additional information within 30 days. Under this section's enforcement provisions, PDP sponsors must return any of the amounts disgorged by PBMs back to HHS. HHS will also develop and maintain a confidential reporting mechanism for entities contracted with PBMs to submit alleged violations, along with anti-retaliation protections for reporting entities. Confidential information included within these reports would not be disclosed by HHS except for review by the HHS OIG, Department of Justice, Congressional Budget Office, and other entities tasked with oversight. This provision appropriates $113 million in FY 2026 funding to CMS for implementation, along with an additional $20 million appropriated to the HHS OIG.

The Government Accountability Office would be tasked with developing a report, within two years of enactment, on pharmaceutical supply chain members' compensation as it relates to the price of Part D covered drugs. This would include PBMs, plan sponsors, wholesalers, pharmacies, manufacturers, brokers, and other relevant entities. The Medicare Payment Advisory Commission (MedPAC) would be directed to conduct analysis on agreements between PBMs and PDP plans, including an initial report two years after the relevant data is made available, and a final report two years following the publication of the initial report. MedPAC would receive $1,000,000 in FY 2026 appropriations to conduct this analysis.

<u>Lowering Prescription Drug Costs</u>

- Sec. 6701 – Oversight of Pharmacy Benefit Management Services

This title builds upon the aforementioned Medicare delinking and rebate proposals by extending similar conditions to commercial and employer-sponsored health plans. Section 6701 specifically proposes new transparency and reporting requirements for PBMs contracted with group health plans. This includes a proposed requirement for PBMs contracted with large plans, large employer plans, or plans that have opted-in, to provide plain language, machine readable reports on drug and pricing data to contracted plans every six months, or quarterly upon request. Such reports would be required to include drug-specific data like amounts paid from the plan to PBM, amounts paid by the PBM to pharmacy, and the difference between each amount (also known as the 'spread'). Other required disclosures include information on the drug dispensing channel, Wholesale Acquisition Cost or Average Wholesale Price, National Drug Code (NDC), brand vs generic, total claims data, net price per course of treatment post-rebates, and total out-of-pocket spending by beneficiaries for such drug. Such reports must also include data on a plan's total net spend, as well as the total amount of rebates and fees collected by both the plan and PBM. Reports must also include data on manufacturer copay assistance provided. In addition to drug-specific data, PBMs would be required to report on data for each therapeutic class for which a claim was filed, such as gross and net spending levels, the amount of rebates received by the PBM, average net spending per 30- and 90-day supply, the number of patients and NDCs utilized, a description of the formulary tiers and utilization management strategies employed, and total beneficiary out-of-pocket spending. For high-cost drugs, i.e. those with gross spending over $10,000 during a reporting period or the 50 drugs with the highest spend during a reporting period, PBMs would submit reports on therapeutic alternatives, a justification behind the formulary placement of such drug, and any changes in formulary placement compared to the previous

plan year. For PBMs with affiliate pharmacies, the biannual reports must include an explanation of any pharmacy steering-related policies, the percentage of drugs dispensed by affiliates, and a list of all drugs dispensed by affiliates and their costs compared to independent pharmacies. Group health plans, health insurance issuers, and PBMs are barred from entering into new contracts until they agree to disclose the information necessary for PBMs to compile such statutorily required reports.

To assist plan sponsors, PBMs must compile summary documents upon request which include "information the Secretary determines useful to group health plans for the purposes of selecting pharmacy benefit management services" such as an estimated net price, costs per claim, estimated cost per beneficiary, and the reimbursement model utilized. PBMs must also compile summaries that plans may offer to beneficiaries, which cover aggregate drug cost and outcomes data. Beneficiaries would receive a right to request claims-level information on the difference received by PBMs and paid to pharmacies for applicable drugs, as well as brokerage fees. PBM reports must comply with HIPAA privacy parameters and may only provide summary health information to plans. Plans may only disclose the information received in PBM reports back to the PBM or to a business associate of the applicable PBM. PBMs may implement reasonable restrictions on additional public disclosures but may not block the disclosure of reported information to HHS, the Department of Labor, or the Department of the Treasury. Within 18 months of enactment, the HHS Secretary must establish a standard reporting format. PBMs and plans that fail to meet the reporting requirements would be subject to a civil monetary penalty of up to $10,000 per day the violation continues, or up to $100,000 for each instance of knowingly providing false information.

- Sec. 6702 – Full Rebate Pass Through to Plan; Exception for Innocent Plan Fiduciaries

This section would extend the full rebate pass through framework, also found in Section 6224, to PBMs contracted with commercial plans. Under this section, PBM contracts that do not pass 100% of rebates, fees, and other remuneration on to commercial plans will not be considered reasonable. PBM income is again limited to bona fide service fees. PBMs are required to remit payments quarterly, with payments due within 90 days of the end of each quarter. Rebate aggregators and other purchasing entities must also remit rebates to the PBM within 45 days of the end of each quarter. Plans are granted the right to audit their rebate records annually, but PBMs are not required to cover the costs of such audits. This provision only applies to contracts agreed upon after the effective date, while existing contracts are not affected. Under this section's transparency requirements, PBMs must fully disclose and enumerate all rebates, fees, and discounts received. The exception for innocent plan fiduciaries constitutes a safe harbor from enforcement for plans that did not realize the contracted PBM failed to pass through 100% of rebates, realized and requested full pass-through in writing, or realized, requested full pass-through, and notified HHS of further PBM noncompliance within 90 days. The legislative language also clarifies the definition of a "covered service provider" under ERISA to include PBM and consulting services, benefits administration selection, group purchasing organization agreements, and other third-party administration services. These provisions would be effective 30 months after enactment of the bill.