

Warner's Wide-Ranging Health Reform Bill Reverses H.R. 1 Cuts, Creates Public Option

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Virginia Democratic Sen. Mark Warner Thursday introduced a wide-ranging health care package that calls for reversing the cuts to Medicaid, permanently funding the enhanced Affordable care Act tax credits, and laying a path to universal coverage via a public option available to those not enrolled in an employer-covered plan.

In a statement to IHP, Warner, who is running for a fourth term in office against Republican Bert Mizusawa, says the legislation “will serve as the focus for my health care plan should I get rehired for another term.”

Warner notes the Health for the Commonwealth through Affordability, Reform, and Expansion Act of 2026 (Health CARE Act) builds off his Health Care Improvement Act of 2021 and his other legislative work to make health care more affordable and accessible.

“Our health care system is too expensive and makes it hard for Americans to access care,” Warner says. “Americans are being crushed by rising costs from everyday goods like gas and groceries to their utility bills, medicine, and health care premiums. My new Health CARE Act repeals harmful provisions from HR1 that are, hypocritically, not supposed to be enacted until after Election Day. It also helps to bridge the coverage gap and lower costs for the millions of Americans on Medicare, Medicaid, and those who get insurance through their employer.”

The bill includes six sections.

Provisions in the first section would reverse most of the health care cuts from the GOP's reconciliation bill, while maintaining the Rural Health Transformation Fund, the ability to use telehealth services pre-deductible, and Medicare pay increase for doctors in 2026.

The next section, “Pathway to Universal Coverage,” includes the creation of a public health option for which HHS would be required to ensure costs are no more than other exchange products. The secretary would also be required to establish competitive provider payment rates using the best information publicly available and data otherwise available, and with consideration of commercial plan rates and the costs to deliver care. HHS would also have authority to require providers in Medicare and Medicaid to participate.

The package also aims to strengthen Medicaid by reinstating higher federal payments for states that opt-in to the Medicaid expansion. It would also protect the joint federal-state program from economic downturns by linking the federal payments to state unemployment levels.

The bill would expand the Medicare drug negotiation program so that it must cover 50 drugs by 2032 and every year after. It would extend 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. The bill would also extend the Medicare Part B and Medicare Part D inflation rebates to drugs in the commercial market, and establish a \$2,000 out-of-pocket limit for individual and group health plans.

To ensure quality health insurance and remove barriers to care, the legislation requires group and individual plans to offer a timely exceptions process for medication and step therapy.

The bill includes reforms to the Medicare Advantage prior authorization processes, and enrollees in MA would also have a special enrollment period if their provider is terminated from their plan network.

Medicare would be required to cover hearing services including comprehensive evaluations and hearing aids.

The final section of the bill codifies transparency requirements for hospitals, and extends price transparency requirements to ambulatory surgical centers, labs and imaging services. It also codifies transparency requirements for health plans. It further clarifies that the third-party administrators and pharmacy benefit managers must give certain large employers and group plans access to full claims and encounter data.

It would also require group and individual plans to provide an explanation of benefits and hold enrollees harmless from charges that are substantially more than the estimates, unless the costs were for medically needed items that could not have reasonably been foreseen. The legislation also requires providers to inform patients of their right to an itemized bill -- and bars balance billing or pursuing collections from patients if the billed amount is more than the good faith estimate or the amount posted by a facility.

This legislation is endorsed by Community Catalyst, Families USA, Small Business Majority, Virginia Community Healthcare Association, Virginia Poverty Law Center, and Virginia Rural Health Association. -- *Amy Lotven* (alotven@iwpnews.com)