

118TH CONGRESS
1ST SESSION

H. R. 4883

To amend title XVIII of the Social Security Act to require the disclosure of certain ownership information relating to health care provider and pharmacy ownership, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 25, 2023

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

A BILL

To amend title XVIII of the Social Security Act to require the disclosure of certain ownership information relating to health care provider and pharmacy ownership, 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 “Medicare Common
5 Ownership Transparency Act of 2023”.

6 **SEC. 2. REPORT ON INTEGRATION IN MEDICARE.**

7 (a) REQUIRED MA AND PDP REPORTING.—

1 (1) MA PLANS.—Section 1857(e) of the Social
2 Security Act (42 U.S.C. 1395w–27(e)) is amended
3 by adding at the end the following new paragraph:

4 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-
5 FORMATION RELATING TO HEALTH CARE PROVIDER
6 OWNERSHIP.—

7 “(A) IN GENERAL.—For plan year 2025
8 and for every third plan year thereafter, each
9 MA organization offering an MA plan under
10 this part during such plan year shall submit to
11 the Secretary, at a time and in a manner speci-
12 fied by the Secretary—

13 “(i) the taxpayer identification num-
14 ber for each health care provider that was
15 a specified health care provider with re-
16 spect to such organization during such
17 year;

18 “(ii) the total amount of incentive-
19 based payments made to, and the total
20 amount of shared losses recoupments col-
21 lected from, such specified health care pro-
22 viders during such plan year; and

23 “(iii) the total amount of incentive-
24 based payments made to, and the total
25 amount of shared losses recoupments col-

1 lected from, providers of services and sup-
2 pliers not described in clause (ii) during
3 such plan year.

4 “(B) DEFINITION.—For purposes of this
5 paragraph, the term ‘specified health care pro-
6 vider’ means, with respect to an MA organiza-
7 tion and a plan year, a provider of services or
8 supplier with respect to which such organization
9 (or any person with an ownership or control in-
10 terest (as defined in section 1124(a)(3)) in such
11 organization) is a person with an ownership or
12 control interest (as so defined).”.

13 (2) PRESCRIPTION DRUG PLANS.—Section
14 1860D–12(b) of the Social Security Act (42 U.S.C.
15 1395w–112(b)) is amended by adding at the end the
16 following new paragraph:

17 “(9) PROVISION OF INFORMATION RELATING TO
18 PHARMACY OWNERSHIP.—

19 “(A) IN GENERAL.—For plan year 2025
20 and for every third plan year thereafter, each
21 PDP sponsor offering a prescription drug plan
22 under this part during such plan year shall sub-
23 mit to the Secretary, at a time and in a manner
24 specified by the Secretary, the taxpayer identi-
25 fication number and National Provider Identifi-

1 fier for each pharmacy that was a specified
2 pharmacy with respect to such sponsor during
3 such year.

4 “(B) DEFINITION.—For purposes of this
5 paragraph, the term ‘specified pharmacy’
6 means, with respect to an PDP sponsor offering
7 a prescription drug plan and a plan year, a
8 pharmacy with respect to which—

9 “(i) such sponsor (or any person with
10 an ownership or control interest (as de-
11 fined in section 1124(a)(3)) in such spon-
12 sor) is a person with an ownership or con-
13 trol interest (as so defined); or

14 “(ii) a pharmacy benefit manager of-
15 fering services under such plan (or any
16 person with an ownership or control inter-
17 est (as so defined) in such sponsor) is a
18 person with an ownership or control inter-
19 est (as so defined).”.

20 (b) MEDPAC REPORTS.—Part E of title XVIII of the
21 Social Security Act (42 U.S.C. 1395x et seq.) is amended
22 by adding at the end the following new section:

1 **“SEC. 1899C. REPORTS ON VERTICAL INTEGRATION UNDER**
2 **MEDICARE.**

3 “(a) IN GENERAL.—Not later than June 15, 2029,
4 and every 3 years thereafter, the Medicare Payment Advi-
5 sory Commission shall submit to Congress a report on the
6 state of vertical integration in the health care sector dur-
7 ing the applicable year with respect to entities partici-
8 pating in the Medicare program, including health care pro-
9 viders, pharmacies, prescription drug plan sponsors, Medi-
10 care Advantage organizations, and pharmacy benefit man-
11 agers. Such report shall include—

12 “(1) with respect to Medicare Advantage orga-
13 nizations, the evaluation described in subsection (b);
14 “(2) with respect to prescription drug plans,
15 pharmacy benefit managers, and pharmacies, the
16 comparisons and evaluations described in subsection
17 (c);

18 “(3) with respect to Medicare Advantage plans
19 under which benefits are available for physician-ad-
20 ministered drugs, the information described in sub-
21 section (d); and

22 “(4) the identifications described in subsection
23 (e); and

24 “(5) an analysis of the impact of such integra-
25 tion on health care access, price, quality, and out-
26 comes.

1 “(b) MEDICARE ADVANTAGE ORGANIZATIONS.—For
2 purposes of subsection (a)(1), the evaluation described in
3 this subsection is, with respect to Medicare Advantage or-
4 ganizations and an applicable year, an evaluation, taking
5 into account patient acuity and the types of areas serviced
6 by such organization, of—

7 “(1) the average number of qualifying diag-
8 noses made during such year with respect to enroll-
9 ees of a Medicare Advantage plan offered by such
10 organization who, during such year, received a
11 health risk assessment from a specified health care
12 provider;

13 “(2) the average risk score for such enrollees
14 who received such an assessment during such year;

15 “(3) any relationship between such risk scores
16 for such enrollees receiving such an assessment from
17 such a provider during such year and incentive pay-
18 ments made to such providers;

19 “(4) the average risk score for enrollees of such
20 plan who received any item or service from a speci-
21 fied health care provider during such year;

22 “(5) any relationship between the risk scores of
23 enrollees under such plan and whether the enrollees
24 have received any item or service from a specified
25 provider; and

1 “(6) any relationship between the risk scores of
2 enrollees under such plan that have received any
3 item or service from a specified provider and incen-
4 tive payments made under the plan to specified pro-
5 viders.

6 “(c) PRESCRIPTION DRUG PLANS.—For purposes of
7 subsection (a)(2), the comparisons and evaluations de-
8 scribed in this subsection are, with respect to prescription
9 drug plans and an applicable year, the following:

10 “(1) For each covered part D drug for which
11 benefits are available under such a plan, a compari-
12 son of the average negotiated rate in effect with
13 specified pharmacies with such rates in effect for in-
14 network pharmacies that are not specified phar-
15 macies.

16 “(2) Comparisons of the following:

17 “(A) The total amount paid by pharmacy
18 benefit managers to specified pharmacies for
19 covered part D drugs and the total amount so
20 paid to pharmacies that are not specified phar-
21 macies for such drugs.

22 “(B) The total amount paid by such spon-
23 sors to specified pharmacy benefit managers as
24 reimbursement for covered part D drugs and
25 the total amount so paid to pharmacy benefit

1 managers that are not specified pharmacy ben-
2 efit managers as such reimbursement.

3 “(C) Fees paid under by plan to specified
4 pharmacy benefit managers compared to such
5 fees paid to pharmacy benefit managers that
6 are not specified pharmacy benefit managers.

7 “(3) An evaluation of the total amount of direct
8 and indirect remuneration for covered part D drugs
9 passed through to prescription drug plan sponsors
10 and the total amount retained by pharmacy benefit
11 managers (including entities under contract with
12 such a manager).

13 “(4) To the extent that the available data per-
14 mits, an evaluation of fees charged by rebate
15 aggregators that are affiliated with plan sponsors.

16 “(d) PHYSICIAN-ADMINISTERED DRUGS.—For pur-
17 poses of subsection (a)(3), the information described in
18 this subsection is, with respect to physician-administered
19 drugs for which benefits are available under a Medicare
20 Advantage plan during an applicable year, the following:

21 “(1) With respect to each such plan, an identi-
22 fication of each drug for which benefits were avail-
23 able under such plan only when administered by a
24 health care provider that acquired such drug from
25 an affiliated pharmacy.

1 “(2) An evaluation of the difference between
2 the total number of drugs administered by a health
3 care provider that were acquired from affiliated
4 pharmacies compared to the number of such drugs
5 so administered that were acquired from pharmacies
6 other than affiliated pharmacies, and an evaluation
7 of the difference in payments for such drugs so ad-
8 ministered when acquired from a specified pharmacy
9 and when acquired from a pharmacy that is not a
10 specified pharmacy.

11 “(3) An evaluation of the dollar value of all
12 such drugs that were not so administered because of
13 a delay attributable to an affiliated pharmacy com-
14 pared to the dollar value of all such drugs that were
15 not so administered because of a delay attributable
16 to pharmacy that is not an affiliated pharmacy.

17 “(4) The number of enrollees administered such
18 a drug that was acquired from an affiliated phar-
19 macy.

20 “(5) The number of enrollees furnished such a
21 drug that was acquired from a pharmacy that is not
22 an affiliated pharmacy.

23 “(e) IDENTIFICATIONS.—For purposes of subsection
24 (a)(4), the identifications described in this subsection are,
25 with respect to an applicable year, identifications of each

1 health care entity participating under the Medicare pro-
2 gram with respect to which another health care entity so
3 participating is a person with an ownership or control in-
4 terest (as defined in section 1124(a)(3) of the Social Secu-
5 rity Act (42 U.S.C. 1320a-3(a)(3))).

6 “(f) DEFINITIONS.—In this section:

7 “(1) AFFILIATED PHARMACY.—The term ‘affili-
8 ated pharmacy’ means, with respect to a Medicare
9 Advantage plan offered by a Medicare Advantage or-
10 ganization, a pharmacy with respect to which such
11 organization (or any person with an ownership or
12 control interest (as defined in section 1124(a)(3)) in
13 such organization) is a person with an ownership or
14 control interest (as so defined).

15 “(2) APPLICABLE YEAR.—The term ‘applicable
16 year’ means, with respect to a report submitted
17 under subsection (a), the first calendar year begin-
18 ning at least 4 years prior to the date of the submis-
19 sion of such report.

20 “(3) COVERED PART D DRUG.—The term ‘cov-
21 ered part D drug’ has the meaning given such term
22 in section 1860D-2(e).

23 “(4) DIRECT AND INDIRECT REMUNERATION.—
24 The term ‘direct and indirect remuneration’ has the
25 meaning given such term in section 423.308 of title

1 42, Code of Federal Regulations (or any successor
2 regulation).

3 “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-
4 fying diagnosis’ means, with respect to an enrollee of
5 a Medicare Advantage plan, a diagnosis that is
6 taken into account in calculating a risk score for
7 such enrollee under the risk adjustment methodology
8 established by the Secretary pursuant to section
9 1853(a)(3).

10 “(6) RISK SCORE.—The term ‘risk score’
11 means, with respect to an enrollee of a Medicare Ad-
12 vantage plan, the score calculated for such individual
13 using the methodology described in paragraph (5).

14 “(7) PHYSICIAN-ADMINISTERED DRUG.—The
15 term ‘physician-administered drug’ means a drug
16 furnished to an individual that, had such individual
17 been enrolled under part B and not enrolled under
18 part C, would have been payable under section
19 1842(o).

20 “(8) SPECIFIED HEALTH CARE PROVIDER.—
21 The term ‘specified health care provider’ means,
22 with respect to a Medicare Advantage plan offered
23 by a Medicare Advantage organization, a health care
24 provider with respect to which such organization (or
25 any person with an ownership or control interest (as

1 defined in section 1124(a)(3)) in such organization)
2 is a person with an ownership or control interest (as
3 so defined).

4 “(9) SPECIFIED PHARMACY.—The term ‘speci-
5 fied pharmacy’ means, with respect to a prescription
6 drug plan offered by a prescription drug plan spon-
7 sor, a pharmacy with respect to which—

8 “(A) such sponsor (or any person with an
9 ownership or control interest (as defined in sec-
10 tion 1124(a)(3)) in such sponsor) is a person
11 with an ownership or control interest (as so de-
12 fined); or

13 “(B) a pharmacy benefit manager offering
14 services under such plan (or any person with an
15 ownership or control interest (as so defined) in
16 such sponsor) is a person with an ownership or
17 control interest (as so defined).

18 “(10) SPECIFIED PHARMACY BENEFIT MAN-
19 AGER.—The term ‘specified pharmacy benefit man-
20 ager’ means, with respect to a prescription drug
21 plan offered by a prescription drug plan sponsor, a
22 pharmacy benefit manager with respect to which
23 such sponsor (or any person with an ownership or
24 control interest (as defined in section 1124(a)(3)) in

1 such sponsor) is a person with an ownership or con-
2 trol interest (as so defined).”.

