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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

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Common Ownership Transparency Act of 2023''.

SEC. 2. REPORT ON INTEGRATION IN MEDICARE.

(a) REQUIRED MA AND PDP REPORTING.—

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

"(6) REQUIRED DISCLOSURE OF CERTAIN INFORMATION RELATING TO HEALTH CARE PROVIDER OWNERSHIP.—

"(A) IN GENERAL.—For plan year 2025 and for every third plan year thereafter, each MA organization offering an MA plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary—

"(i) the taxpayer identification number for each health care provider that was a specified health care provider with respect to such organization during such year;

"(ii) the total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from, such specified health care providers during such plan year; and

"(iii) the total amount of incentive-based payments made to, and the total amount of shared losses recoupments col-

lected from, providers of services and suppliers not described in clause (ii) during such plan year.

''(B) DEFINITION.—For purposes of this paragraph, the term 'specified health care provider' means, with respect to an MA organization and a plan year, a provider of services or supplier with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such organization) is a person with an ownership or control interest (as so defined).''.

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

''(9) PROVISION OF INFORMATION RELATING TO PHARMACY OWNERSHIP.—

''(A) IN GENERAL.—For plan year 2025 and for every third plan year thereafter, each PDP sponsor offering a prescription drug plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary, the taxpayer identification number and National Provider Identi-

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

"(B) DEFINITION.—For purposes of this paragraph, the term 'specified pharmacy' means, with respect to an PDP sponsor offering a prescription drug plan and a plan year, a pharmacy with respect to which—

"(i) such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such sponsor) is a person with an ownership or control interest (as so defined); or

"(ii) a pharmacy benefit manager offering services under such plan (or any person with an ownership or control interest (as so defined) in such sponsor) is a person with an ownership or control interest (as so defined).".

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

"SEC. 1899C. REPORTS ON VERTICAL INTEGRATION UNDER MEDICARE.

"(a) IN GENERAL.—Not later than June 15, 2029, and every 3 years thereafter, the Medicare Payment Advisory Commission shall submit to Congress a report on the state of vertical integration in the health care sector during the applicable year with respect to entities participating in the Medicare program, including health care providers, pharmacies, prescription drug plan sponsors, Medicare Advantage organizations, and pharmacy benefit managers. Such report shall include—

"(1) with respect to Medicare Advantage organizations, the evaluation described in subsection (b);

"(2) with respect to prescription drug plans, pharmacy benefit managers, and pharmacies, the comparisons and evaluations described in subsection (c);

"(3) with respect to Medicare Advantage plans under which benefits are available for physician-administered drugs, the information described in subsection (d); and

"(4) the identifications described in subsection (e); and

"(5) an analysis of the impact of such integration on health care access, price, quality, and outcomes.

''(b) MEDICARE ADVANTAGE ORGANIZATIONS.—For purposes of subsection (a)(1), the evaluation described in this subsection is, with respect to Medicare Advantage organizations and an applicable year, an evaluation, taking into account patient acuity and the types of areas serviced by such organization, of—

''(1) the average number of qualifying diagnoses made during such year with respect to enrollees of a Medicare Advantage plan offered by such organization who, during such year, received a health risk assessment from a specified health care provider;

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

''(3) any relationship between such risk scores for such enrollees receiving such an assessment from such a provider during such year and incentive payments made to such providers;

''(4) the average risk score for enrollees of such plan who received any item or service from a specified health care provider during such year;

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

''(6) any relationship between the risk scores of enrollees under such plan that have received any item or service from a specified provider and incentive payments made under the plan to specified providers.

''(c) PRESCRIPTION DRUG PLANS.—For purposes of subsection (a)(2), the comparisons and evaluations described in this subsection are, with respect to prescription drug plans and an applicable year, the following:

''(1) For each covered part D drug for which benefits are available under such a plan, a comparison of the average negotiated rate in effect with specified pharmacies with such rates in effect for in-network pharmacies that are not specified pharmacies.

''(2) Comparisons of the following:

''(A) The total amount paid by pharmacy benefit managers to specified pharmacies for covered part D drugs and the total amount so paid to pharmacies that are not specified pharmacies for such drugs.

''(B) The total amount paid by such sponsors to specified pharmacy benefit managers as reimbursement for covered part D drugs and the total amount so paid to pharmacy benefit

managers that are not specified pharmacy benefit managers as such reimbursement.

''(C) Fees paid under by plan to specified pharmacy benefit managers compared to such fees paid to pharmacy benefit managers that are not specified pharmacy benefit managers.

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

''(4) To the extent that the available data permits, an evaluation of fees charged by rebate aggregators that are affiliated with plan sponsors.

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

''(1) With respect to each such plan, an identification of each drug for which benefits were available under such plan only when administered by a health care provider that acquired such drug from an affiliated pharmacy.

''(2) An evaluation of the difference between the total number of drugs administered by a health care provider that were acquired from affiliated pharmacies compared to the number of such drugs so administered that were acquired from pharmacies other than affiliated pharmacies, and an evaluation of the difference in payments for such drugs so administered when acquired from a specified pharmacy and when acquired from a pharmacy that is not a specified pharmacy.

''(3) An evaluation of the dollar value of all such drugs that were not so administered because of a delay attributable to an affiliated pharmacy compared to the dollar value of all such drugs that were not so administered because of a delay attributable to pharmacy that is not an affiliated pharmacy.

''(4) The number of enrollees administered such a drug that was acquired from an affiliated pharmacy.

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

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

health care entity participating under the Medicare program with respect to which another health care entity so participating is a person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act (42 U.S.C. 1320a–3(a)(3))).

''(f) DEFINITIONS.—In this section:

''(1) AFFILIATED PHARMACY.—The term 'affiliated pharmacy' means, with respect to a Medicare Advantage plan offered by a Medicare Advantage organization, a pharmacy with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such organization) is a person with an ownership or control interest (as so defined).

''(2) APPLICABLE YEAR.—The term 'applicable year' means, with respect to a report submitted under subsection (a), the first calendar year beginning at least 4 years prior to the date of the submission of such report.

''(3) COVERED PART D DRUG.—The term 'covered part D drug' has the meaning given such term in section 1860D–2(e).

''(4) DIRECT AND INDIRECT REMUNERATION.—The term 'direct and indirect remuneration' has the meaning given such term in section 423.308 of title

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

''(5) QUALIFYING DIAGNOSIS.—The term 'qualifying diagnosis' means, with respect to an enrollee of a Medicare Advantage plan, a diagnosis that is taken into account in calculating a risk score for such enrollee under the risk adjustment methodology established by the Secretary pursuant to section 1853(a)(3).

''(6) RISK SCORE.—The term 'risk score' means, with respect to an enrollee of a Medicare Advantage plan, the score calculated for such individual using the methodology described in paragraph (5).

''(7) PHYSICIAN-ADMINISTERED DRUG.—The term 'physician-administered drug' means a drug furnished to an individual that, had such individual been enrolled under part B and not enrolled under part C, would have been payable under section 1842(o).

''(8) SPECIFIED HEALTH CARE PROVIDER.—The term 'specified health care provider' means, with respect to a Medicare Advantage plan offered by a Medicare Advantage organization, a health care provider with respect to which such organization (or any person with an ownership or control interest (as

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

''(9) SPECIFIED PHARMACY.—The term 'specified pharmacy' means, with respect to a prescription drug plan offered by a prescription drug plan sponsor, a pharmacy with respect to which—

''(A) such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such sponsor) is a person with an ownership or control interest (as so defined); or

''(B) a pharmacy benefit manager offering services under such plan (or any person with an ownership or control interest (as so defined) in such sponsor) is a person with an ownership or control interest (as so defined).

''(10) SPECIFIED PHARMACY BENEFIT MANAGER.—The term 'specified pharmacy benefit manager' means, with respect to a prescription drug plan offered by a prescription drug plan sponsor, a pharmacy benefit manager with respect to which such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in

such sponsor) is a person with an ownership or control interest (as so defined).''.

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