

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.

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## 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.

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).”.

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