[DISCUSSION DRAFT]

118TH CONGRESS
1ST SESSION

H. R. _____

To amend title XVIII of the Social Security Act to promote transparency of common ownership interests under parts C and D of the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

M__. _____ introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to promote transparency of common ownership interests under parts C and D of the Medicare program.

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 "_____ Act of 2023".

SEC. 2. PROMOTING TRANSPARENCY OF COMMON OWNERSHIP INTERESTS UNDER PARTS C AND D OF THE MEDICARE PROGRAM.

(a) MEDICARE ADVANTAGE.—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 years beginning on or after January 1, 2025, a contract under this section with an MA organization shall require the organization to report to the Secretary, at a time and in a manner specified by the Secretary, the information described in subparagraph (B) with respect to such plan year.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to an MA organization and a plan year, the following:

"(i) The number of claims for items and services furnished during such plan year by a specified provider (as defined in

subparagraph (C)) paid by such organization.

''(ii) The number of claims for items and services furnished during such plan year by a provider of services or supplier not described in clause (i) paid by such organization.

''(iii) The average per-enrollee number of qualifying diagnoses (as defined in subparagraph (C)) made during such plan year by specified providers (including through chart reviews and home risk assessments) with respect to individuals enrolled under an MA plan offered by such organization, broken down by type of provider (such as primary care and specialty care), as specified by the Secretary.

''(iv) The average per-enrollee number of qualifying diagnoses made during such plan year by providers of services and suppliers not described in clause (iii) (including through such reviews and assessments) with respect to such individuals, broken down by type of provider (as specified for purposes of such clause).

''(v) The average risk score (as calculated under the methodology described in subparagraph (C)(i)) for such an individual for such plan year who received items and services from a specified provider during such plan year.

''(vi) The average risk score for such an individual for such plan year who did not receive items and services from a provider of services or suppliers described in clause (v) during such plan year.

''(vii) The average risk score for such an individual for such plan year who received items and services from a provider that was furnishing such items and services under contract with an assessment entity that was a specified assessment entity.

''(viii) The average risk score for such an individual for such plan year who received items and services from a provider that was furnishing such items and services under contract with an assessment entity that was not a specified assessment entity.

''(ix) The number of prior authorization requests for an item or service submitted to such organization during such plan year, the number of such requests that were approved, the number of such requests that were denied, and the number of such denied requests that were subsequently appealed and then approved, broken down by whether the entity proposing to furnish such item or service was a specified provider or not a specified provider.

''(x) For each MA plan offered by such organization during such plan year—

''(I) the average premium for such plan;

''(II) the total amount expended under such plan as payment for items and services furnished by a specified provider during such year;

''(III) the total amount expended under such plan as payment for items and services furnished by a provider not described in subclause (II) during such year;

''(IV) the average medical loss ratio under such plan with respect to individuals furnished an item or service from a specified provider during such year; and

''(V) the average medical loss ratio under such plan with respect to individuals not described in subclause (IV).

''(C) DEFINITIONS.—In this paragraph:

''(i) ASSESSMENT ENTITY.—The term 'assessment entity' means an entity with a focus on furnishing in-home medical assessments, as specified by the Secretary.

''(ii) QUALIFYING DIAGNOSIS.—The term 'qualifying diagnosis' means a diagnosis that is taken into account under the risk adjustment methodology established by the Secretary pursuant to section 1853(a)(3).

''(iii) SPECIFIED ASSESSMENT ENTITY.—The term 'specified assessment entity' means, with respect to an MA organization and a plan year, an assessment entity 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).

''(iv) SPECIFIED PROVIDER.—The term 'specified 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).''.

(b) PHARMACY BENEFIT MANAGER AND PHARMACY INFORMATION.—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 paragraphs:

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

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2025, a contract entered into under this part with a PDP sponsor shall require the sponsor to report to the

Secretary, at a time and in a manner specified by the Secretary, the information described in subparagraph (B) with respect to such plan year.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, for each prescription drug plan offered by a PDP sponsor for a plan year, the following:

''(i) The negotiated price for each covered part D drug for which benefits are available under such plan for each in-network pharmacy (including an identification of whether each such pharmacy is a specified pharmacy).

''(ii) The average per-drug amount of direct and indirect remuneration paid by specified pharmacies for such covered part D drugs dispensed during such plan year under such plan.

''(iii) The average per-drug amount of direct and indirect remuneration paid by pharmacies not described in clause (ii) for such covered part D drugs dispensed during such plan year under such plan.

"(C) DEFINITIONS.—In this paragraph:

"(i) 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).

"(ii) IN-NETWORK PHARMACY.—The term 'in-network pharmacy' means, with respect to a prescription drug plan offered by a PDP sponsor, a pharmacy with a contract in effect with such sponsor to dispense covered part D drugs under such plan.

"(iii) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 1860D–14A(g)(6).

"(iv) SPECIFIED PHARMACY.—The term 'specified pharmacy' means, with respect to an PDP sponsor and a plan year, a pharmacy 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).

"(10) PROVISION OF INFORMATION BY PHARMACY BENEFIT MANAGERS.—

"(A) IN GENERAL.—For plan years beginning on or after January 1, 2025, a contract entered into under this part with a PDP sponsor shall prohibit such sponsor from entering into a contract with a specified pharmacy benefit manager for purposes of performing any service with respect to covered part D drugs dispensed under any prescription drug plan offered by such sponsor for such plan year unless such manager agrees to report to the Secretary, at a time and in a manner specified by the Secretary, the information described in subparagraph (B) with respect to each prescription drug plan for which such manager is providing any such service during such plan year, regardless of the sponsor of such plan.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a pharmacy benefit manager performing serv-

ices under a prescription drug plan for a plan year, the following:

''(i) With respect to the total amount of pharmacy and manufacturer rebates collected by such manager (or collected on behalf of such plan by any other entity with a contract in effect with such manager for such collection) for all covered part D drugs dispensed under such plan during such plan year—

''(I) the total amount of such rebates passed through to the PDP sponsor of such plan; and

''(II) the total amount of such rebates retained by such manager or such other entities.

''(ii) The total amount paid by such manager to pharmacies for drugs furnished under such plan during such plan year.

''(iii) The total amount of payments made by such sponsor to such manager as reimbursement for such manager's payments described in clause (ii).

''(iv) The total amount of payments made by such sponsor to such manager as

fees for services furnished by such manager with respect to such plan for such plan year (not including payments described in clause (iii)).

''(v) The total amount of administrative costs incurred by such manager for furnishing such services under such plan for such plan year.

''(vi) A specification as to whether such manager is a specified pharmacy benefit manager with respect to the PDP sponsor of such plan.

''(C) DEFINITION.—In this paragraph, the term 'specified pharmacy benefit manager' means, with respect to an PDP sponsor and a plan year, 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).

''(11) PROVISION OF INFORMATION BY PHARMACIES.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2025, a contract

entered into under this part with a PDP sponsor shall prohibit such sponsor from entering into a contract with a specified pharmacy for purposes of dispensing covered part D drugs dispensed under any prescription drug plan offered by such sponsor for such plan year unless such pharmacy agrees to report to the Secretary, at a time and in a manner specified by the Secretary, the information described in subparagraph (B) with respect to each prescription drug plan for which such pharmacy has a contract in effect for dispensing covered part D drugs during such plan year, regardless of the sponsor of such plan.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a pharmacy dispensing covered part D drugs under a prescription drug plan for a plan year, the following:

''(i) The negotiated price for each covered part D drug for which benefits are available under such plan that may be dispensed by such pharmacy.

"(ii) The average per-drug amount of direct and indirect remuneration paid by such pharmacy to such plan for such covered part D drugs dispensed during such plan year under such plan.

"(iii) A specification as to whether such pharmacy is a specified pharmacy with respect to the PDP sponsor of such plan.

"(C) ELECTION TO REPORT INFORMATION FOR NONSPECIFIED PHARMACIES.—The Secretary shall provide a process under which a pharmacy that is not a specified pharmacy may elect to report the information described in subparagraph (B) with respect to a prescription drug plan to the Secretary in the same manner as a specified pharmacy submits such information.

"(D) DEFINITIONS.—In this paragraph, the terms 'direct and indirect remuneration', 'negotiated price', and 'specified pharmacy' have the meanings given such terms in paragraph (9).".

(c) PROVISION OF INFORMATION BY SPECIFIED PROVIDERS.—Section 1866(j) of the Social Security Act (42

U.S.C. 1395cc(j)) is amended by adding at the end the following new paragraph:

"(10) REQUIRED DISCLOSURE OF INFORMATION RELATING TO COMMON OWNERSHIP WITH MA ORGANIZATIONS.—

"(A) IN GENERAL.—Beginning January 1, 2025, as a condition of enrollment (and maintenance of enrollment) under this title, a provider of services or supplier that is a specified provider with respect to any MA organization for a plan year shall agree to submit to the Secretary, at a time and in a manner specified by the Secretary, the information described in subparagraph (B) with respect to such plan year.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a provider of services or supplier and a plan year, the following:

"(i) The number of claims submitted by such provider or supplier for items and services furnished to enrollees of an applicable MA plan during such plan year .

"(ii) The number of claims submitted by such provider or supplier for items and

services furnished to enrollees of an MA plan that is not an applicable MA plan during such plan year.

''(iii) The average per-enrollee number of qualifying diagnoses (as defined in subparagraph (C)) made during such plan year by such provider of services or supplier with respect to individuals enrolled under an applicable MA plan.

''(iv) The average per-enrollee number of qualifying diagnoses (as so defined) made during such plan year by such provider of services or supplier with respect to individuals enrolled under an MA plan that is not an applicable MA plan.

''(v) The number of prior authorization requests for an item or service submitted by such provider of services or supplier to all MA plans during such plan year, the number of such requests that were approved, the number of such requests that were denied, and the number of such denied requests that were subsequently appealed and then approved, broken down by such requests submitted to

applicable MA plans and such requests submitted to plans that are not applicable MA plans.

''(C) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE MA PLAN.—The term 'applicable MA plan' means, with respect to a provider of services or supplier, an MA plan offered by an MA organization with respect to which such provider or supplier is a specified provider.

''(ii) QUALIFYING DIAGNOSIS.—The term 'qualifying diagnosis' means a diagnosis that is taken into account under the risk adjustment methodology established by the Secretary pursuant to section 1853(a)(3).

''(iii) SPECIFIED PROVIDER.—The term 'specified 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).''.

(d) PUBLICATION.—Not later than January 1, 2027, the Secretary of Health and Human Services shall establish a process under which information submitted to the Secretary pursuant to the amendments made by this section is publicly disclosed. Such process shall ensure that any information so disclosed does not identify a specific drug manufacturer, provider of services or supplier, pharmacy, pharmacy benefit manager, or any price charged with respect to a particular drug.