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(Original Signature of Member)

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

Mrs. HARSHBARGER (for herself and Ms. SCHRIER) 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 ''Promoting Transparency and Healthy Competition in Medicare Act''.

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, not later than 1 year after the last day of such plan year, 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 items and services furnished during such plan year by each specified provider (as defined in subpara-

graph (C)) for which payment was made by such organization.

''(ii) The number of items and services furnished during such plan year by providers of services or suppliers not described in clause (i) for which payment was made 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 health risk assessments) with respect to individuals enrolled under an MA plan offered by such organization, broken down by site of service of such providers, 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 site of service of such providers.

''(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 specified provider during such plan year.

''(vii) The average risk score for such an individual for such plan year who received a health risk assessment from an assessment entity that was a specified assessment entity during such plan year.

''(viii) The average risk score for such an individual for such plan year who received a health risk assessment from an assessment entity that was not a specified assessment entity during such plan year.

''(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 re-

quests 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) The total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from, specified providers during such plan year.

''(xi) The total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from, providers of services and suppliers not described in clause (x) during such plan year.

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

''(I) the total amount of payments made under section 1853(a)(1) to such organization for coverage of individuals under such plan, and the total amount of payments made by

such individuals to such organization for coverage under such plan;

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

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

''(IV) the 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 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, with respect to an individual, a diagnosis that is taken into account in calculating a risk score for such individual 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).

''(D) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to information collected under this paragraph.''.

(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, not later than 1 year after the last day of such plan year, 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 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) NETWORK PHARMACY.—The term 'network pharmacy' has the meaning

given such term in section 423.100 of title 42, Code of Federal Regulations (or any successor regulation).

''(iii) NEGOTIATED PRICE.—The 'negotiated price' for a covered part D drug shall take into account all negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for such drug, and include any dispensing fee for such drug.

''(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).

''(D) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to information collected under this paragraph.

''(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, not later than 1 year after the last day of such plan year, 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 services 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 be-

half 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).".

(c) 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, phar-

macy, pharmacy benefit manager, or any price charged with respect to a particular drug.