

119TH CONGRESS
1ST SESSION

H. R. 5433

To prohibit health insurance issuers and certain health care providers under Medicare from being under common ownership, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 17, 2025

Ms. HOYLE of Oregon (for herself, Mr. RYAN, Ms. JAYAPAL, and Ms. OCASIO-CORTEZ) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committees on Energy and Commerce, and Ways and Means, 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 prohibit health insurance issuers and certain health care providers under Medicare from being under common 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 “Patients Over Profit
5 Act” or the “POP Act”.

1 **SEC. 2. PROHIBITION ON COMMON OWNERSHIP OF HEALTH**
2 **INSURANCE ISSUERS AND CERTAIN HEALTH**
3 **CARE PROVIDERS UNDER MEDICARE.**

4 (a) IN GENERAL.—It shall be unlawful for any per-
5 son to both—

6 (1) directly or indirectly own, operate, or con-
7 trol the whole or any part of an applicable provider
8 or a management services organization that has a
9 management services agreement with an applicable
10 provider; and

11 (2) directly or indirectly own, operate, or con-
12 trol the whole or any part of a health insurance
13 issuer.

14 (b) DIVESTMENT.—Any person in violation of sub-
15 section (a) shall divest either the applicable provider (or,
16 if applicable, the management services organization) or
17 the health insurance issuer of such person—

18 (1) in the case of an applicable provider, man-
19 agement services organization, or health insurance
20 issuer acquired on or before the date of enactment
21 of this Act, not later than 2 years after such date
22 of enactment; or

23 (2) in the case of an applicable provider, man-
24 agement services organization, or health insurance
25 issuer acquired after the date of enactment of this

1 Act, not later than 1 year after the date of acqui-
2 sition.

3 (c) CIVIL ACTIONS.—

4 (1) IN GENERAL.—When the Inspector General
5 of the Department of Health and Human Services,
6 the Assistant Attorney General in charge of the
7 Antitrust Division of the Department of Justice, the
8 Federal Trade Commission, or an attorney general
9 of a State has reason to believe that a person is in
10 violation of subsection (a) or (b), such Inspector
11 General, Assistant Attorney General, Federal Trade
12 Commission, or attorney general of a State may
13 bring a civil action in an applicable district court of
14 the United States for the relief described in para-
15 graph (2).

16 (2) INJUNCTIVE AND EQUITABLE RELIEF.—In
17 any action described in paragraph (1), the applicable
18 court, on a finding that a person is in violation of
19 subsection (a) or (b), shall issue an order requiring
20 such person—

21 (A) to cease and desist from such violation,
22 and divest either the applicable provider (or, if
23 applicable, the management services organiza-
24 tion) or the health insurance issuer of such per-
25 son; and

1 (B) to disgorge any revenue received from
2 the provision of health care services during the
3 period of such violation.

4 (3) DEPOSIT AND DISTRIBUTION.—Any revenue
5 disgorged pursuant to an action under this sub-
6 section for a violation of subsection (a) or (b) shall
7 be deposited into a fund created by the Federal
8 Trade Commission and distributed by the Federal
9 Trade Commission to be put to use in the interest
10 of serving the health care needs of the harmed com-
11 munity. Receipt of any funds under this paragraph
12 shall not alter or diminish the rights of an individual
13 to bring an action or recover any amount as other-
14 wise authorized by law.

15 (d) FTC REVIEW.—

16 (1) REPORTING REQUIRED.—Any divestment of
17 an applicable provider, management services organi-
18 zation, or health insurance issuer required under
19 subsection (b) shall be reported to the Federal
20 Trade Commission and the Assistant Attorney Gen-
21 eral in charge of the Antitrust Division of the De-
22 partment of Justice under section 7A of the Clayton
23 Act (15 U.S.C. 18a) without respect to the thresh-
24 olds under subsection (a)(2) of that section.

1 (2) TOLLING OF DIVESTMENT PERIOD DURING
2 REVIEW.—The divestment period under subsection
3 (b) shall be tolled during the pendency of any wait-
4 ing period required under section 7A of the Clayton
5 Act (15 U.S.C. 18a).

6 (3) REVIEW OF EFFECT OF DIVESTITURE.—
7 With respect to each divestiture undertaken pursu-
8 ant to subsection (b), in addition to any applicable
9 review under section 7A of the Clayton Act (15
10 U.S.C. 18a), the Federal Trade Commission and the
11 Assistant Attorney General in charge of the Anti-
12 trust Division of the Department of Justice shall re-
13 view the effect on competition, financial viability,
14 and the public interest—

15 (A) of the divestiture; and

16 (B) of the subsequent acquisition of the
17 applicable provider (or, if applicable, the man-
18 agement services organization) or the health in-
19 surance issuer of such person by the acquiring
20 person.

21 (e) RULEMAKING AUTHORITY.—The Federal Trade
22 Commission shall promulgate rules to carry out this sec-
23 tion. Such rules shall not diminish any obligation under
24 this section.

1 (f) RULE OF CONSTRUCTION.—Nothing in this sec-
 2 tion shall be construed to limit the authority of the Fed-
 3 eral Trade Commission, the Inspector General of the De-
 4 partment of Justice, the Department of Health and
 5 Human Services, or the attorney general of a State under
 6 any other provision of law.

7 (g) ENFORCEMENT UNDER MEDICARE ADVANTAGE
 8 AND MEDICARE PART D.—

9 (1) MEDICARE ADVANTAGE.—Section 1857 of
 10 the Social Security Act (42 U.S.C. 1395w–27) is
 11 amended by adding at the end the following new
 12 subsection:

13 “(j) PROHIBITION ON COMMON OWNERSHIP OF MA
 14 ORGANIZATIONS AND APPLICABLE PROVIDERS.—

15 “(1) IN GENERAL.—For plan years beginning
 16 on or after January 1, 2026, the Secretary may not
 17 contract with, or provide payment under this part
 18 to, a Medicare Advantage organization with respect
 19 to offering an MA plan or MA–PD plan under this
 20 part if the organization—

21 “(A) directly or indirectly owns, operates,
 22 or controls the whole or any part of an applica-
 23 ble provider or a management services organiza-
 24 tion that has a management services agreement
 25 with an applicable provider; or

1 “(B) is directly or indirectly owned, oper-
2 ated, or controlled in whole or part by a person
3 who also directly or indirectly owns, operates,
4 or controls the whole or any part of an applica-
5 ble provider or a management services organiza-
6 tion that has a management services agreement
7 with an applicable provider.

8 “(2) CERTIFICATION.—Each Medicare Advan-
9 tage organization shall furnish to the Secretary (in
10 a form and manner, and at a time, specified by the
11 Secretary) a certification of compliance with this
12 subsection, as well as such information as the Sec-
13 retary determines necessary to carry out this sub-
14 section.

15 “(3) FALSE CLAIMS SUBMITTED BY ENTITIES
16 IN VIOLATION OF PROHIBITION ON COMMON OWNER-
17 SHIP.—Any claim for payment from an entity in vio-
18 lation of paragraph (1) constitutes a false or fraudu-
19 lent claim for purposes of subchapter III of title 31,
20 United States Code.

21 “(4) DEFINITIONS.—In this subsection:

22 “(A) APPLICABLE PROVIDER.—

23 “(i) IN GENERAL.—Subject to clause
24 (ii), the term ‘applicable provider’ means
25 any entity that receives payment for fur-

nishing services covered under part B or under a Medicare Advantage plan under part C.

“(ii) EXCLUSIONS.—Such term does not include—

“(I) a hospital (as defined in section 1861(e)), a critical access hospital (as defined in section 1861(mm)(1)), or a rural emergency hospital (as defined in section 1861(kkk)(2));

“(II) a supplier of durable medical equipment, prosthetics, orthotics, or supplies; or

“(III) a pharmacy.

“(B) MANAGEMENT SERVICES AGREEMENT.—The term ‘management services agreement’ means a contract between a management services organization and an applicable provider for management or administrative services relating to, supporting, or facilitating the provision of health care services.

“(C) MANAGEMENT SERVICES ORGANIZATION.—The term ‘management services organization’ means any organization or entity that

contracts with an applicable provider to perform management or administrative services relating to, supporting, or facilitating the provision of health care services.”.

(2) MEDICARE PART D.—Section 1860D–12(b)(3) of the Social Security Act (42 U.S.C. 1395w–112(b)(3)) is amended by adding at the end the following new subparagraph:

“(G) PROHIBITION ON COMMON OWNERSHIP.—Section 1857(j).”.

(h) DEFINITIONS.—In this section:

(1) APPLICABLE PROVIDER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term “applicable provider” means any entity that receives payment for furnishing services covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) or under a Medicare Advantage plan under part C of such title (42 U.S.C. 1395w–21 et seq.).

(B) EXCLUSIONS.—Such term does not include—

(i) a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))), a critical access hos-

1 pital (as defined in section 1861(mm)(1) of
2 such Act (42 U.S.C. 1395x(mm)(1))), or a
3 rural emergency hospital (as defined in
4 section 1861(kkk)(2));

5 (ii) a supplier of durable medical
6 equipment, prosthetics, orthotics, and sup-
7 plies; or

8 (iii) a pharmacy.

9 (2) HEALTH INSURANCE ISSUER.—The term
10 “health insurance issuer” has the meaning given
11 that term in section 2791 of the Public Health Serv-
12 ice Act (42 U.S.C. 300gg–91).

13 (3) MANAGEMENT SERVICES AGREEMENT.—
14 The term “management services agreement” means
15 a contract between a management services organiza-
16 tion and an applicable provider for management or
17 administrative services relating to, supporting, or fa-
18 cilitating the provision of health care services.

19 (4) MANAGEMENT SERVICES ORGANIZATION.—
20 The term “management services organization”
21 means any organization or entity that contracts with
22 an applicable provider to perform management or
23 administrative services relating to, supporting, or fa-
24 cilitating the provision of health care services.

1 (5) PERSON.—The term “person” has the
2 meaning given the term in section 8 of the Sherman
3 Act (15 U.S.C. 7).

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