Suspend the Rules and Pass the Bill, H.R. 3514, With an Amendment

(The amendment strikes all after the enacting clause and inserts a new text)

119TH CONGRESS
2D SESSION

H. R. 3514

To amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans.

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 2025

Mr. KELLY of Pennsylvania (for himself, Ms. DELBENE, Mr. JOYCE of Pennsylvania, Mr. BERA, Ms. VAN DUYNE, Ms. CHU, Mr. CRENSHAW, Ms. CLARKE of New York, Mr. MURPHY, Ms. MOORE of Wisconsin, Mr. BALDERSON, Ms. SCHRIER, Mr. YAKYM, Ms. SEWELL, Mrs. HARSHBARGER, Mr. LARSON of Connecticut, Mr. CAREY, Mr. EVANS of Pennsylvania, Ms. MALLIOTAKIS, Mr. BEYER, Ms. TENNEY, Ms. TOKUDA, Mrs. MILLER of West Virginia, Ms. STEVENS, Mr. FITZPATRICK, Mr. COSTA, Mr. SMUCKER, Ms. PRESSLEY, Mr. LAHOOD, Mr. DAVIS of North Carolina, Mr. MEUSER, Mr. POCAN, Ms. SALAZAR, Mr. FIELDS, Mr. BACON, Mr. FOSTER, Mr. MANN, Ms. BROWNLEY, Mr. CISCOMANI, Mr. CONAWAY, Mr. FINSTAD, Ms. BONAMICI, Mr. SHREVE, Ms. NORTON, Mrs. KIGGANS of Virginia, Mr. DELUZIO, Mr. THOMPSON of Pennsylvania, Mr. MRVAN, Mr. MOULTON, Mr. CASE, Ms. MCBRIDE, Ms. ROSS, Ms. BUDZINSKI, Mr. QUIGLEY, Mr. SORENSEN, Mr. MCGARVEY, Ms. DAVIDS of Kansas, Ms. BROWN, Mr. CROW, Mr. TORRES of New York, Ms. WASSERMAN SCHULTZ, Mr. STANTON, Mr. LEVIN, Mr. KEATING, Ms. JOHNSON of Texas, Mr. VICENTE GONZALEZ of Texas, Ms. GOODLANDER, Ms. CRAIG, Mr. GOLDMAN of New York, Ms. BARRAGÁN, Ms. BALINT, Mr. RYAN, Ms. HOULAHAN, and Mrs. MILLER-MEEKS) 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 establish requirements with respect to the use of prior authorization under Medicare Advantage plans.

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 ''Improving Seniors' Timely Access to Care Act of 2026''.

SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of an MA plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (5)) during a plan year beginning on or after January 1, 2029, such plan shall—

''(A) establish the electronic prior authorization program described in paragraph (2);

''(B) meet the transparency requirements specified in paragraph (3); and

"(C) meet the enrollee protection standards specified pursuant to paragraph (4).

"(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—

"(i) a prior authorization request from a provider to an MA plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider; and

"(ii) any supporting documentation relating to such request or response.

"(B) ELECTRONIC TRANSMISSION.—

"(i) EXCLUSIONS.—For purposes of this paragraph, a facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission described in subparagraph (A).

''(ii) STANDARDS.—An electronic transmission described in subparagraph (A) shall comply with applicable technical standards and other requirements to promote the standardization and streamlining of electronic transactions adopted by the Secretary.

''(3) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the transparency requirements specified in this paragraph are, with respect to an MA plan and a plan year, the following:

''(i) The plan, at a time and in a manner specified by the Secretary, shall submit to the Secretary and post on a publicly-accessible website of such plan the following information with respect to such plan year:

''(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan.

''(II) The percentage and number of specified requests (as defined in subparagraph (F)) approved by the

plan in an initial determination and the percentage and number of specified requests denied by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(III) The percentage and number of specified requests that were denied by the plan in an initial determination and that were subsequently appealed.

''(IV) The percentage and number of appeals of specified requests resolved, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

''(V) The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved,

by the plan through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(VI) The average and the median amount of time (in hours) that elapsed between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service (excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan), categorized by such requests that were for expedited determinations (as described in subsection (g)(3)) and such requests that were not for expedited determinations.

''(VII) The average and the median amount of time (in hours) that elapsed between the submission of a specified request to the plan that is

subsequently appealed and a final determination on such appeals with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan.

''(VIII) The percentage and number of specified requests that were excluded from the calculation described in subclause (VI), and the percentage and number of specified requests that were excluded from the calculation described in subclause (VII), based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(IX) The percentage and number of instances in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior au-

thorization request, the provider furnishing such item or service determined that a different or additional item or service was medically necessary, and a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

''(X) A disclosure and description of any technology described in subclause (V) that the plan utilized in making determinations with respect to specified requests.

''(XI) The number of grievances (as described in subsection (f)) received by such plan that were related to a prior authorization requirement.

''(XII) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider that seeks to enter into a contract with such plan to furnish applicable items and services under such plan, the list described in clause (i)(I) and any poli-

cies or procedures used by the plan for making determinations with respect to prior authorization requests;

''(II) to each such provider that enters into such a contract, access to the criteria used by the plan for making such determinations and an itemization of the medical or other documentation required to be submitted by a provider with respect to such a request; and

''(III) to an enrollee of the plan, upon request, access to such criteria.

''(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of the information described in subparagraph (A)(i) submitted to the Secretary with respect to a plan year, an MA plan may elect to include information regarding the percentage and number of specified requests made with respect to an item or service that were denied by the plan in an initial determination based on such requests failing to demonstrate that individuals requesting to receive such item or service met

the clinical criteria used by such plan to receive such item or service.

''(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, establish requirements for MA plans regarding the provision of—

''(i) access to criteria described in subparagraph (A)(ii)(II) to providers in accordance with such subparagraph; and

''(ii) access to such criteria to enrollees in accordance with subparagraph (A)(ii)(III).

''(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information described in subparagraph (A)(i) and subparagraph (B) on a public website of the Centers for Medicare & Medicaid Services. Such information shall be so published on an individual plan level and may in addition be aggregated in such manner as determined appropriate by the Secretary.

''(E) MEDPAC REPORT.—Not later than the first June 15 occurring after the date that is 2 years after the date information submitted under subparagraph (A)(i) is made available to

the Medicare Payment Advisory Commission, the Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency of appeals and overturned decisions. The Commission shall provide recommendations, as appropriate, on any improvement that should be made to the electronic prior authorization programs of MA plans.

''(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term 'specified request' means a prior authorization request made with respect to an applicable item or service.

''(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(C), with respect to the use of prior authorization by MA plans for applicable items and services, the enrollee protection standards specified in this paragraph are—

''(A) the adoption of transparent prior authorization programs developed in consultation with enrollees and with providers with contracts

in effect with such plans for furnishing such items and services under such plans;

''(B) allowing for the waiver or modification of prior authorization requirements based on the performance of such providers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

''(C) conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from physicians who meet such criteria as may be specified by the Secretary and other stakeholders (including enrollees and providers with such contracts in effect) and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

''(5) APPLICABLE ITEM OR SERVICE DEFINED.—For purposes of this subsection, the term 'applicable item or service' means, with respect to an MA plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) REPORTS TO CONGRESS.—

''(A) GAO.—Not later than January 1, 2032, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by MA plans.

''(B) HHS.—

''(i) THE SECRETARY.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and again not later than the end of the seventh plan year after such date of enactment and the ninth plan year after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

''(I) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

''(II) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.

''(ii) CMS.—Not later than January 1, 2032, the Centers for Medicare & Medicaid Services and the Office of National Coordinator for Health Information Technology shall submit to Congress and publish on the internet website of the Centers for Medicare & Medicaid Services a report that—

''(I) defines the term 'real-time decision' and details how the definition for such term may be updated based on any technological advances;

''(II) using the data submitted to the Secretary under paragraph (3)(A)(i), details a process for real-time decisions for routinely approved items and services for purposes of the electronic prior authorization program described in paragraph (2) (which the Secretary may, if determined appropriate by the Secretary, require to be implemented by MA plans as part of

such program pursuant to subsection (g)); and

''(III) includes an analysis of—

''(aa) items and services that are routinely approved;

''(bb) items and services identified in item (aa) that could be subject to real-time decisions;

''(cc) whether requiring real-time decisions for such items and services could—

''(AA) improve enrollee access to benefits covered under the original medicare fee-for-service program under parts A and B;

''(BB) produce operational efficiencies for providers and MA plans; and

''(CC) reduce health disparities for enrollees of MA plans in rural and low-income communities; and

''(dd) how determinations of routinely approved items and

services made solely through automation and artificial intelligence by MA plans impact patient access, including disparities in access for rural and low-income enrollees of MA plans.''.

(b) TIMELY RESPONSES.—Section 1852(g)(1)(A) of the Social Security Act (42 U.S.C. 1395w–22(g)(1)(A)) is amended by inserting ''(which may include timelines for such determinations of 7 days or fewer, if determined practicable by the Secretary)'' after ''basis''.