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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 DUYN, 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

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.

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 “Improving Seniors’
5 Timely Access to Care Act of 2025”.

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

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

12 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

13 “(1) IN GENERAL.—In the case of a Medicare
14 Advantage plan that imposes any prior authorization
15 requirement with respect to any applicable item or
16 service (as defined in paragraph (5)) during a plan
17 year, such plan shall—

18 “(A) beginning with plan years beginning
19 on or after January 1, 2028—

20 “(i) establish the electronic prior au-
21 thORIZATION program described in para-
22 graph (2); and

1 “(ii) meet the enrollee protection
2 standards specified pursuant to paragraph
3 (4); and

4 “(B) beginning with plan years beginning
5 on or after January 1, 2027, meet the trans-
6 parency requirements specified in paragraph
7 (3).

8 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
9 GRAM.—

10 “(A) IN GENERAL.—For purposes of para-
11 graph (1)(A), the electronic prior authorization
12 program described in this paragraph is a pro-
13 gram that provides for the secure electronic
14 transmission of—

15 “(i) a prior authorization request
16 from a provider or supplier to a Medicare
17 Advantage plan with respect to an applica-
18 ble item or service to be furnished to an in-
19 dividual and a response, in accordance with
20 this paragraph, from such plan to such
21 provider or supplier; and

22 “(ii) any supporting documentation
23 relating to such request or response.

24 “(B) ELECTRONIC TRANSMISSION.—

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

8 “(ii) STANDARDS.—An electronic
9 transmission described in subparagraph
10 (A) shall comply with applicable technical
11 standards and other requirements to pro-
12 mote the standardization and streamlining
13 of electronic transactions adopted by the
14 Secretary.

15 “(3) TRANSPARENCY REQUIREMENTS.—

16 “(A) IN GENERAL.—For purposes of para-
17 graph (1)(B), the transparency requirements
18 specified in this paragraph are, with respect to
19 a Medicare Advantage plan, the following:

20 “(i) The plan, annually and in a man-
21 ner specified by the Secretary, shall submit
22 to the Secretary the following information:

23 “(I) A list of all applicable items
24 and services that were subject to a
25 prior authorization requirement under

1 the plan during the previous plan
2 year.

3 “(II) The percentage and number
4 of specified requests (as defined in
5 subparagraph (F)) approved during
6 the previous plan year by the plan in
7 an initial determination and the per-
8 centage and number of specified re-
9 quests denied during such plan year
10 by such plan in an initial determina-
11 tion (both in the aggregate and cat-
12 egorized by each item and service).

13 “(III) The percentage and num-
14 ber of specified requests that were de-
15 nied during the previous plan year by
16 the plan in an initial determination
17 and that were subsequently appealed.

18 “(IV) The number of appeals of
19 specified requests resolved during the
20 preceding plan year, and the percent-
21 age and number of such resolved ap-
22 peals that resulted in approval of the
23 furnishing of the item or service that
24 was the subject of such request, cat-
25 egorized by each applicable item and

1 service and categorized by each level
2 of appeal (including judicial review).

3 “(V) The percentage and number
4 of specified requests that were denied,
5 and the percentage and number of
6 specified requests that were approved,
7 by the plan during the previous plan
8 year through the utilization of deci-
9 sion support technology, artificial in-
10 telligence technology, machine-learn-
11 ing technology, clinical decision-mak-
12 ing technology, or any other tech-
13 nology specified by the Secretary.

14 “(VI) The average and the me-
15 dian amount of time (in hours) that
16 elapsed during the previous plan year
17 between the submission of a specified
18 request to the plan and a determina-
19 tion by the plan with respect to such
20 request for each such item and serv-
21 ice, excluding any such requests that
22 were not submitted with the medical
23 or other documentation required to be
24 submitted by the plan.

1 “(VII) The percentage and num-
2 ber of specified requests that were ex-
3 cluded from the calculation described
4 in subclause (VI) based on the plan’s
5 determination that such requests were
6 not submitted with the medical or
7 other documentation required to be
8 submitted by the plan.

9 “(VIII) Information on each oc-
10 currence during the previous plan
11 year in which, during a surgical or
12 medical procedure involving the fur-
13 nishing of an applicable item or serv-
14 ice with respect to which such plan
15 had approved a prior authorization re-
16 quest, the provider or supplier fur-
17 nishing such item or service deter-
18 mined that a different or additional
19 item or service was medically nec-
20 essary, including a specification of
21 whether such plan subsequently ap-
22 proved the furnishing of such dif-
23 ferent or additional item or service.

24 “(IX) A disclosure and descrip-
25 tion of any technology described in

1 subclause (V) that the plan utilized
2 during the previous plan year in mak-
3 ing determinations with respect to
4 specified requests.

5 “(X) The number of grievances
6 (as described in subsection (f)) re-
7 ceived by such plan during the pre-
8 vious plan year that were related to a
9 prior authorization requirement.

10 “(XI) Such other information as
11 the Secretary determines appropriate.

12 “(ii) The plan shall provide—

13 “(I) to each provider or supplier
14 who seeks to enter into a contract
15 with such plan to furnish applicable
16 items and services under such plan,
17 the list described in clause (i)(I) and
18 any policies or procedures used by the
19 plan for making determinations with
20 respect to prior authorization re-
21 quests;

22 “(II) to each such provider and
23 supplier that enters into such a con-
24 tract, access to the criteria used by
25 the plan for making such determina-

1 tions and an itemization of the med-
2 ical or other documentation required
3 to be submitted by a provider or sup-
4 plier with respect to such a request;
5 and

6 “(III) to an enrollee of the plan,
7 upon request, access to the criteria
8 used by the plan for making deter-
9 minations with respect to prior au-
10 thorization requests for an item or
11 service.

12 “(B) OPTION FOR PLAN TO PROVIDE CER-
13 TAIN ADDITIONAL INFORMATION.—As part of
14 the information described in subparagraph
15 (A)(i) provided to the Secretary during a plan
16 year, a Medicare Advantage plan may elect to
17 include information regarding the percentage
18 and number of specified requests made with re-
19 spect to an individual and an item or service
20 that were denied by the plan during the pre-
21 ceding plan year in an initial determination
22 based on such requests failing to demonstrate
23 that such individuals met the clinical criteria
24 established by such plan to receive such items
25 or services.

1 “(C) REGULATIONS.—The Secretary shall,
2 through notice and comment rulemaking, estab-
3 lish requirements for Medicare Advantage plans
4 regarding the provision of—

5 “(i) access to criteria described in
6 subparagraph (A)(ii)(II) to providers of
7 services and suppliers in accordance with
8 such subparagraph; and

9 “(ii) access to such criteria to enroll-
10 ees in accordance with subparagraph
11 (A)(ii)(III).

12 “(D) PUBLICATION OF INFORMATION.—
13 The Secretary shall publish information de-
14 scribed in subparagraph (A)(i) and subpara-
15 graph (B) on a public website of the Centers
16 for Medicare & Medicaid Services. Such infor-
17 mation shall be so published on an individual
18 plan level and may in addition be aggregated in
19 such manner as determined appropriate by the
20 Secretary.

21 “(E) MEDPAC REPORT.—Not later than 3
22 years after the date information is first sub-
23 mitted under subparagraph (A)(i), the Medicare
24 Payment Advisory Commission shall submit to
25 Congress a report on such information that in-

1 includes a descriptive analysis of the use of prior
2 authorization. As appropriate, the Commission
3 should report on statistics including the fre-
4 quency of appeals and overturned decisions.
5 The Commission shall provide recommenda-
6 tions, as appropriate, on any improvement that
7 should be made to the electronic prior author-
8 ization programs of Medicare Advantage plans.

9 “(F) SPECIFIED REQUEST DEFINED.—For
10 purposes of this paragraph, the term ‘specified
11 request’ means a prior authorization request
12 made with respect to an applicable item or serv-
13 ice.

14 “(4) ENROLLEE PROTECTION STANDARDS.—
15 For purposes of paragraph (1)(A)(ii), with respect
16 to the use of prior authorization by Medicare Advan-
17 tage plans for applicable items and services, the en-
18 rollee protection standards specified in this para-
19 graph are—

20 “(A) the adoption of transparent prior au-
21 thorization programs developed in consultation
22 with enrollees and with providers and suppliers
23 with contracts in effect with such plans for fur-
24 nishing such items and services under such
25 plans;

1 “(B) allowing for the waiver or modifica-
2 tion of prior authorization requirements based
3 on the performance of such providers and sup-
4 pliers in demonstrating compliance with such
5 requirements, such as adherence to evidence-
6 based medical guidelines and other quality cri-
7 teria; and

8 “(C) conducting annual reviews of such
9 items and services for which prior authorization
10 requirements are imposed under such plans
11 through a process that takes into account input
12 from enrollees and from providers and suppliers
13 with such contracts in effect and is based on
14 consideration of prior authorization data from
15 previous plan years and analyses of current cov-
16 erage criteria.

17 “(5) APPLICABLE ITEM OR SERVICE DE-
18 FINED.—For purposes of this subsection, the term
19 ‘applicable item or service’ means, with respect to a
20 Medicare Advantage plan, any item or service for
21 which benefits are available under such plan, other
22 than a covered part D drug.

23 “(6) REPORTS TO CONGRESS.—

24 “(A) GAO.—Not later than January 1,
25 2032, the Comptroller General of the United

1 States shall submit to Congress a report con-
2 taining an evaluation of the implementation of
3 the requirements of this subsection and an
4 analysis of issues in implementing such require-
5 ments faced by Medicare Advantage plans.

6 “(B) HHS.—

7 “(i) THE SECRETARY.—Not later than
8 the end of the fifth plan year beginning
9 after the date of the enactment of this sub-
10 section, and biennially thereafter through
11 the date that is 10 years after such date
12 of enactment, the Secretary shall submit to
13 Congress a report containing a description
14 of the information submitted under para-
15 graph (3)(A)(i) during—

16 “(I) in the case of the first such
17 report, the fourth plan year beginning
18 after the date of the enactment of this
19 subsection; and

20 “(II) in the case of a subsequent
21 report, the 2 plan years preceding the
22 year of the submission of such report.

23 “(ii) CMS.—Not later than January
24 1, 2028, the Centers for Medicare & Med-
25 icaid Services and the Office of National

1 Coordinator for Health Information Tech-
2 nology shall submit to Congress and pub-
3 lish on the internet website of the Centers
4 for Medicare & Medicaid Services a report
5 that—

6 “(I) defines the term ‘real-time
7 decision’ and details how the defini-
8 tion for such term may be updated
9 based on any technological advances;

10 “(II) using the data submitted to
11 the Secretary under paragraph
12 (3)(A)(i), details a process for real-
13 time decisions for routinely approved
14 items and services for purposes of the
15 electronic prior authorization program
16 described in paragraph (2); and

17 “(III) includes an analysis of—

18 “(aa) items and services
19 that are routinely approved;

20 “(bb) items and services
21 identified in item (aa) that could
22 be eligible for real-time decisions;

23 “(cc) whether establishing
24 real-time decisions for such items
25 and services could—

1 “(AA) improve enrollee
2 access to benefits under this
3 part;

4 “(BB) produce oper-
5 ational efficiencies for pro-
6 viders and suppliers and
7 Medicare Advantage plans;
8 and

9 “(CC) reduce health
10 disparities for Medicare Ad-
11 vantage enrollees in rural
12 and low-income commu-
13 nities; and

14 “(dd) how determinations of
15 routinely approved items and
16 services made solely through au-
17 tomation and artificial intel-
18 ligence by Medicare Advantage
19 plans impact patient access, in-
20 cluding disparities in access for
21 rural and low-income bene-
22 ficiaries.”.

23 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-
24 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-
25 TION REQUESTS SUBMITTED UNDER PART C.—Section

1 1852(g) of the Social Security Act (42 U.S.C. 1395w-
2 22(g)) is amended—

3 (1) in paragraph (1)(A), by inserting “and in
4 accordance with any timeframe established by the
5 Secretary under paragraph (6)” after “paragraph
6 (3)”;

7 (2) in paragraph (3)(B)(iii), by inserting “(with
8 respect to prior authorization requests submitted on
9 or after the first day of the third plan year begin-
10 ning after the date of the enactment of the Improv-
11 ing Seniors’ Timely Access to Care Act of 2025, any
12 timeframe established by the Secretary under para-
13 graph (6))” after “72 hours”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-
17 THORIZATION REQUESTS.—Subject to paragraph
18 (3), the Secretary may establish, for purposes of an
19 organization determination made with respect to a
20 prior authorization request for an item or service to
21 be furnished to an individual, timeframes, such as
22 24 hours, for the organization to notify the enrollee
23 (and the physician involved, as appropriate) of such
24 determination for—

1 “(A) a request for expedited determination
2 described in paragraph (3)(A);

3 “(B) a real time decision for routinely ap-
4 proved items and services; and

5 “(C) any other prior authorization re-
6 quest.”.

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