

118TH CONGRESS  
2D SESSION

# H. R. 8702

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

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 12, 2024

Mr. KELLY of Pennsylvania (for himself, Ms. DELBENE, Mr. BUCSHON, Mr. BERA, Mr. SMITH of Nebraska, Mr. PASCRELL, Mr. PFLUGER, Ms. CRAIG, Mr. MOORE of Utah, Mr. KILDEE, Mr. LATTA, Ms. DEGETTE, Ms. VAN DUYNE, Mr. SCHNEIDER, Mr. CARTER of Georgia, Ms. MATSUI, Mr. WENSTRUP, Mr. BEYER, Mr. CRENSHAW, Mr. SARBANES, Mr. FITZPATRICK, Ms. MOORE of Wisconsin, Mrs. HARSHBARGER, Ms. BLUNT ROCHESTER, Mrs. MILLER of West Virginia, Mr. GOMEZ, Mr. PENCE, Mrs. TRAHAN, Ms. TENNEY, Mr. EVANS, Mr. BILIRAKIS, Ms. BARRAGÁN, Mr. LAHOOD, Mr. PANETTA, Mr. JAMES, Ms. CLARKE of New York, Mr. SCHWEIKERT, Mr. LARSON of Connecticut, Mrs. MILLER-MEEKS, Mr. FERGUSON, Ms. CHU, Mr. BURGESS, Mr. MURPHY, Ms. SÁNCHEZ, Mr. JOYCE of Pennsylvania, Mr. STEUBE, Ms. SEWELL, Mr. DUNN of Florida, Mrs. FISCHBACH, Mr. BLUMENAUER, Mr. HUDSON, Mrs. STEEL, Mr. CAREY, Mr. WALBERG, Ms. MALLIOTAKIS, Mr. BALDERSON, Mr. ESTES, Mr. SMUCKER, Mr. SMITH of Washington, Mr. CARSON, Ms. SALINAS, Mr. HARRIS, Mr. AUSTIN SCOTT of Georgia, Ms. PRESSLEY, Mr. LOUDERMILK, Ms. MCCOLLUM, Mr. FOSTER, Mr. ALLRED, Ms. BUSH, Mr. MEUSER, Mr. NEWHOUSE, Mr. ROUZER, Ms. WASSERMAN SCHULTZ, Ms. ROSS, Mr. KILMER, Ms. TITUS, Mr. BACON, Mr. DAVIS of North Carolina, Mr. RUPPERSBERGER, Mr. CASE, Ms. NORTON, Mr. MRVAN, Mr. THOMPSON of Pennsylvania, Ms. MENG, Mr. STANTON, Mr. RESCHENTHALER, Ms. STEVENS, Mr. LATURNER, Mr. RASKIN, Mr. CROW, Mr. JACKSON of North Carolina, Mr. VAN DREW, Mrs. KIGGANS of Virginia, Ms. MCCLELLAN, Mr. NADLER, Ms. TOKUDA, Mr. BANKS, Mr. COSTA, Mr. MOOLENAAR, Mr. RUTHERFORD, Ms. LETLOW, Ms. LOIS FRANKEL of Florida, Ms. DEAN of Pennsylvania, Ms. STANSBURY, Mr. BOST, Mr. QUIGLEY, Ms. WILLIAMS of Georgia, Mr. KRISHNAMOORTHY, Mr. GRIJALVA, Mr. LARSEN of Washington, Mr. TORRES of New York, Mr. MOULTON, Ms. DAVIDS of Kansas, Mr. LYNCH, Mr. COHEN, Ms. WILD, Ms. BONAMICI, Mr. LIEU, Ms. LEGER FERNANDEZ, Mr. SUOZZI, Ms. CARAVEO, Mr. NUNN of Iowa, Mr. HIMES, Mr. BURCHETT, Mrs. FOUSHEE, Mr. MANN, Mr. KIM of New Jersey, Mr.

FLOOD, Mr. EDWARDS, and Ms. SCHRIER) 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.

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 2024”.

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—

1           “(A) beginning with plan years beginning  
2 on or after January 1, 2027—

3           “(i) establish the electronic prior au-  
4 thorization program described in para-  
5 graph (2); and

6           “(ii) meet the enrollee protection  
7 standards specified pursuant to paragraph  
8 (4); and

9           “(B) beginning with plan years beginning  
10 on or after January 1, 2026, meet the trans-  
11 parency requirements specified in paragraph  
12 (3).

13           “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-  
14 GRAM.—

15           “(A) IN GENERAL.—For purposes of para-  
16 graph (1)(A), the electronic prior authorization  
17 program described in this paragraph is a pro-  
18 gram that provides for the secure electronic  
19 transmission of—

20           “(i) a prior authorization request  
21 from a provider of services or supplier to  
22 a Medicare Advantage plan with respect to  
23 an applicable item or service to be fur-  
24 nished to an individual and a response, in

1 accordance with this paragraph, from such  
2 plan to such provider or supplier; and

3 “(ii) any supporting documentation  
4 relating to such request or response.

5 “(B) ELECTRONIC TRANSMISSION.—

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

13 “(ii) STANDARDS.—An electronic  
14 transmission described in subparagraph  
15 (A) shall comply with applicable technical  
16 standards and other requirements to pro-  
17 mote the standardization and streamlining  
18 of electronic transactions adopted by the  
19 Secretary.

20 “(3) TRANSPARENCY REQUIREMENTS.—

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

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

4           “(I) A list of all applicable items  
5 and services that were subject to a  
6 prior authorization requirement under  
7 the plan during the previous plan  
8 year.

9           “(II) The percentage and number  
10 of specified requests (as defined in  
11 subparagraph (F)) approved during  
12 the previous plan year by the plan in  
13 an initial determination and the per-  
14 centage and number of specified re-  
15 quests denied during such plan year  
16 by such plan in an initial determina-  
17 tion (both in the aggregate and cat-  
18 egorized by each item and service).

19           “(III) The percentage and num-  
20 ber of specified requests that were de-  
21 nied during the previous plan year by  
22 the plan in an initial determination  
23 and that were subsequently appealed.

24           “(IV) The number of appeals of  
25 specified requests resolved during the

1 preceding plan year, and the percent-  
2 age and number of such resolved ap-  
3 peals that resulted in approval of the  
4 furnishing of the item or service that  
5 was the subject of such request, cat-  
6 egorized by each applicable item and  
7 service and categorized by each level  
8 of appeal (including judicial review).

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

20 “(VI) The average and the me-  
21 dian amount of time (in hours) that  
22 elapsed during the previous plan year  
23 between the submission of a specified  
24 request to the plan and a determina-  
25 tion by the plan with respect to such

1 request for each such item and serv-  
2 ice, excluding any such requests that  
3 were not submitted with the medical  
4 or other documentation required to be  
5 submitted by the plan.

6 “(VII) The percentage and num-  
7 ber of specified requests that were ex-  
8 cluded from the calculation described  
9 in subclause (VIII) based on the  
10 plan’s determination that such re-  
11 quests were not submitted with the  
12 medical or other documentation re-  
13 quired to be submitted by the plan.

14 “(VIII) Information on each oc-  
15 currence during the previous plan  
16 year in which, during a surgical or  
17 medical procedure involving the fur-  
18 nishing of an applicable item or serv-  
19 ice with respect to which such plan  
20 had approved a prior authorization re-  
21 quest, the provider of services or sup-  
22 plier furnishing such item or service  
23 determined that a different or addi-  
24 tional item or service was medically  
25 necessary, including a specification of

1 whether such plan subsequently ap-  
2 proved the furnishing of such dif-  
3 ferent or additional item or service.

4 “(IX) A disclosure and descrip-  
5 tion of any technology described in  
6 subclause (V) that the plan utilized  
7 during the previous plan year in mak-  
8 ing determinations with respect to  
9 specified requests.

10 “(X) The number of grievances  
11 (as described in subsection (f)) re-  
12 ceived by such plan during the pre-  
13 vious plan year that were related to a  
14 prior authorization requirement.

15 “(XI) Such other information as  
16 the Secretary determines appropriate.

17 “(ii) The plan shall provide—

18 “(I) to each provider or supplier  
19 who seeks to enter into a contract  
20 with such plan to furnish applicable  
21 items and services under such plan,  
22 the list described in clause (i)(I) and  
23 any policies or procedures used by the  
24 plan for making determinations with



1                   respect to prior authorization re-  
2                   quests;

3                   “(II) to each such provider and  
4                   supplier that enters into such a con-  
5                   tract, access to the criteria used by  
6                   the plan for making such determina-  
7                   tions and an itemization of the med-  
8                   ical or other documentation required  
9                   to be submitted by a provider or sup-  
10                  plier with respect to such a request;  
11                  and

12                  “(III) to an enrollee of the plan,  
13                  upon request, access to the criteria  
14                  used by the plan for making deter-  
15                  minations with respect to prior au-  
16                  thorization requests for an item or  
17                  service.

18                  “(B) OPTION FOR PLAN TO PROVIDE CER-  
19                  TAIN ADDITIONAL INFORMATION.—As part of  
20                  the information described in subparagraph  
21                  (A)(i) provided to the Secretary during a plan  
22                  year, a Medicare Advantage plan may elect to  
23                  include information regarding the percentage  
24                  and number of specified requests made with re-  
25                  spect to an individual and an item or service

1 that were denied by the plan during the pre-  
2 ceding plan year in an initial determination  
3 based on such requests failing to demonstrate  
4 that such individuals met the clinical criteria  
5 established by such plan to receive such items  
6 or services.

7 “(C) REGULATIONS.—The Secretary shall,  
8 through notice and comment rulemaking, estab-  
9 lish requirements for Medicare Advantage plans  
10 regarding the provision of—

11 “(i) access to criteria described in  
12 subparagraph (A)(ii)(II) to providers of  
13 services and suppliers in accordance with  
14 such subparagraph; and

15 “(ii) access to such criteria to enroll-  
16 ees in accordance with subparagraph  
17 (A)(ii)(III).

18 “(D) PUBLICATION OF INFORMATION.—  
19 The Secretary shall publish information de-  
20 scribed in subparagraph (A)(i) and subpara-  
21 graph (B) on a public website of the Centers  
22 for Medicare & Medicaid Services. Such infor-  
23 mation shall be so published on an individual  
24 plan level and may in addition be aggregated in

1 such manner as determined appropriate by the  
2 Secretary.

3 “(E) MEDPAC REPORT.—Not later than 3  
4 years after the date information is first sub-  
5 mitted under subparagraph (A)(i), the Medicare  
6 Payment Advisory Commission shall submit to  
7 Congress a report on such information that in-  
8 cludes a descriptive analysis of the use of prior  
9 authorization. As appropriate, the Commission  
10 should report on statistics including the fre-  
11 quency of appeals and overturned decisions.  
12 The Commission shall provide recommenda-  
13 tions, as appropriate, on any improvement that  
14 should be made to the electronic prior author-  
15 ization programs of Medicare Advantage plans.

16 “(F) SPECIFIED REQUEST DEFINED.—For  
17 purposes of this paragraph, the term ‘specified  
18 request’ means a prior authorization request  
19 made with respect to an applicable item or serv-  
20 ice.

21 “(4) ENROLLEE PROTECTION STANDARDS.—  
22 For purposes of paragraph (1)(A)(ii), with respect  
23 to the use of prior authorization by Medicare Advan-  
24 tage plans for applicable items and services, the en-

1 rollee protection standards specified in this para-  
2 graph are—

3 “(A) the adoption of transparent prior au-  
4 thorization programs developed in consultation  
5 with enrollees and with providers and suppliers  
6 with contracts in effect with such plans for fur-  
7 nishing such items and services under such  
8 plans;

9 “(B) allowing for the waiver or modifica-  
10 tion of prior authorization requirements based  
11 on the performance of such providers and sup-  
12 pliers in demonstrating compliance with such  
13 requirements, such as adherence to evidence-  
14 based medical guidelines and other quality cri-  
15 teria; and

16 “(C) conducting annual reviews of such  
17 items and services for which prior authorization  
18 requirements are imposed under such plans  
19 through a process that takes into account input  
20 from enrollees and from providers and suppliers  
21 with such contracts in effect and is based on  
22 consideration of prior authorization data from  
23 previous plan years and analyses of current cov-  
24 erage criteria.

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

7           “(6) REPORTS TO CONGRESS.—

8           “(A) GAO.—Not later than January 1,  
9 2028, the Comptroller General of the United  
10 States shall submit to Congress a report con-  
11 taining an evaluation of the implementation of  
12 the requirements of this subsection and an  
13 analysis of issues in implementing such require-  
14 ments faced by Medicare Advantage plans.

15           “(B) HHS.—

16           “(i) THE SECRETARY.—Not later than  
17 the end of the fifth plan year beginning  
18 after the date of the enactment of this sub-  
19 section, and biennially thereafter through  
20 the date that is 10 years after such date  
21 of enactment, the Secretary shall submit to  
22 Congress a report containing a description  
23 of the information submitted under para-  
24 graph (3)(A)(i) during—

1           “(I) in the case of the first such  
2           report, the fourth plan year beginning  
3           after the date of the enactment of this  
4           subsection; and

5           “(II) in the case of a subsequent  
6           report, the 2 plan years preceding the  
7           year of the submission of such report.

8           “(ii) CMS.—Not later than January  
9           1, 2027, the Centers for Medicare & Med-  
10          icaid Services and the Office of National  
11          Coordinator for Health Information Tech-  
12          nology shall submit to Congress and pub-  
13          lish on the Internet website of the Centers  
14          for Medicare & Medicaid Services a report  
15          that—

16               “(I) defines the term ‘real-time  
17               decision’ and details how the defini-  
18               tion for such term may be updated  
19               based on any technological advances;

20               “(II) using the data submitted to  
21               the Secretary under paragraph  
22               (3)(A)(i), details a process for real-  
23               time decisions for items and services  
24               for routinely approved services for  
25               purposes of the electronic prior au-

1 authorization program described in  
2 paragraph (2); and

3 “(III) includes an analysis of—

4 “(aa) items and services  
5 that are routinely approved;

6 “(bb) items and services  
7 identified in item (aa) that could  
8 be eligible for real-time decisions;

9 “(cc) how establishing real-  
10 time decisions for such items and  
11 services could—

12 “(AA) improve enrollee  
13 access to benefits under this  
14 part;

15 “(BB) produce oper-  
16 ational efficiencies for pro-  
17 viders of services and sup-  
18 pliers and Medicare Advan-  
19 tage plans; and

20 “(CC) reduce health  
21 disparities for Medicare Ad-  
22 vantage enrollees in rural  
23 and low-income commu-  
24 nities; and

1 “(dd) how the use of auto-  
2 mated decision-making and artifi-  
3 cial intelligence by Medicare Ad-  
4 vantage plans impact patient ac-  
5 cess, including disparities in ac-  
6 cess for rural and low-income  
7 beneficiaries, to routinely ap-  
8 proved items and services.”.

9 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-  
10 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-  
11 TION REQUESTS SUBMITTED UNDER PART C.—Section  
12 1852(g) of the Social Security Act (42 U.S.C. 1395w-  
13 22(g)) is amended—

14 (1) in paragraph (1)(A), by inserting “and in  
15 accordance with any timeframe established by the  
16 Secretary under paragraph (6)” after “paragraph  
17 (3)”;

18 (2) in paragraph (3)(B)(iii), by inserting “(or,  
19 subject to subsection (o), with respect to prior au-  
20 thorization requests submitted on or after the first  
21 day of the third plan year beginning after the date  
22 of the enactment of the Improving Seniors’ Timely  
23 Access to Care Act of 2024, any timeframe estab-  
24 lished by the Secretary under paragraph (6))” after  
25 “72 hours”; and



1           (3) by adding at the end the following new  
2 paragraph:

3           “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-  
4 THORIZATION REQUESTS.—Subject to paragraph (3)  
5 and subsection (o), the Secretary may establish, for  
6 purposes of an organization determination made  
7 with respect to a prior authorization request for an  
8 item or service to be furnished to an individual,  
9 timeframes, such as 24 hours, for the organization  
10 to notify the enrollee (and the physician involved, as  
11 appropriate) of such determination for—

12                   “(A) a request for expedited determination  
13 described in paragraph (3)(A);

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

16                   “(C) any other prior authorization re-  
17 quest.”.

○