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119TH CONGRESS
1ST SESSION

H. R. 2433

To ensure that prior authorization medical decisions under Medicare are determined by physicians.

IN THE HOUSE OF REPRESENTATIVES

MARCH 27, 2025

Mr. GREEN of Tennessee (for himself, Mr. MURPHY, Ms. SCHRIER, Mr. JOYCE of Pennsylvania, Mr. MCCORMICK, Mr. HARRIS of Maryland, Mr. BURCHETT, Mr. BABIN, Mrs. MILLER-MEEKS, and Mr. KENNEDY of Utah) 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 ensure that prior authorization medical decisions under Medicare are determined by physicians.

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 ''Reducing Medically Unnecessary Delays in Care Act of 2025''.

SEC. 2. DEFINITIONS.

In this Act:

(1) ADVERSE DETERMINATION.—The term ''adverse determination'' means a decision by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan that administers prior authorization programs under the Medicare program under title XVIII of the Social Security Act or such plan that the health care services furnished or proposed to be furnished to an individual entitled to benefits or enrolled under the Medicare program are not medically necessary, or are experimental or investigational; and benefit coverage under such program or plan for such services is therefore denied, reduced, or terminated.

(2) AUTHORIZATION.—The term ''authorization'' means a determination by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan that administers prior authorization programs under the Medicare program under title XVIII of the Social Security Act or such plan that a health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made under the Medicare program under title

XVIII of the Social Security Act or such plan for that health care service.

(3) CLINICAL CRITERIA.—The term ''clinical criteria'' means the written policies, written screening procedures, drug formularies, or lists of covered drugs, decision rules, decision abstracts, clinical protocols, practice guidelines, and medical protocols used by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan to determine the necessity and appropriateness of health care services.

(4) FINAL ADVERSE DETERMINATION.—The term ''final adverse determination'' means an adverse determination that has been upheld by a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan at the completion of the contractor's appeals process.

(5) HEALTH CARE SERVICE.—The term ''health care service'' means a health care item, service, procedure, treatment, or prescription drug provided by a facility licensed in the State involved or provided by a doctor of medicine, a doctor of osteopathic medicine, or a health care professional licensed in such State.

(6) MEDICALLY NECESSARY HEALTH CARE SERVICE.—The term ''medically necessary health care services'' means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is—

(A) in accordance with generally accepted standards of medical practice;

(B) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(7) MEDICARE ADMINISTRATIVE CONTRACTOR.—The term ''medicare administrative contractor'' means a medicare administrative contractor with a contract under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1).

(8) MEDICARE ADVANTAGE PLAN.—The term ''Medicare Advantage plan'' means a Medicare Advantage plan under part C of title XVIII of the Social Security Act.

(9) PREAUTHORIZATION.—The term ''preauthorization''—

(A) means the process by which a medicare administrative contractor, Medicare Advantage plan, or prescription drug plan determines the medical necessity or medical appropriateness of health care services for which benefits are otherwise provided under the Medicare program under title XVIII of the Social Security Act or such plan prior to the rendering of such health care services, including preadmission review, pretreatment review, utilization, and case management; and

(B) includes any requirement that a patient or health care provider notify the Centers for Medicare & Medicaid Services prior to providing a health care service.

(10) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' means a prescription drug plan under part D of title XVIII of the Social Security Act.

SEC. 3. CONTRACT REQUIREMENTS FOR PRIOR AUTHORIZATION MEDICAL DECISIONS FOR MEDICARE ADMINISTRATIVE CONTRACTORS, MEDICARE ADVANTAGE PLANS, AND PRESCRIPTION DRUG PLANS.

Any contract that applies on or after the date that is 90 days after the date of the enactment of this Act, between the Secretary of Health and Human Services and a medicare administrative contractor under section 1874A of the Social Security Act, a Medicare Advantage organization under section 1857 of such Act with respect to the offering of a Medicare Advantage plan, or a PDP sponsor under section 1860D–12 of such Act with respect to the offering of a prescription drug plan shall require such medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, to comply with each of the following requirements:

(1) MEDICAL NECESSITY.—Any restriction, preauthorization, adverse determination, or final adverse determination that the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, places on the provision of a health care service for the purposes of coverage or payment of such service under the Medicare program under title XVIII of such Act, or under such plan, shall be based on the medical necessity or ap-

propriateness of such service and on written clinical criteria.

(2) EVIDENCE-BASED STANDARDS.—If no independently developed evidence-based standards exist for a particular health care service, the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, may not deny coverage of the health care service based solely on the grounds that the health care service does not meet an evidence-based standard.

(3) INPUT FROM PHYSICIANS.—Prior to establishing, or substantially or materially altering, written clinical criteria for purpose of preauthorization review, the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall obtain input from actively practicing physicians within the service area where the written clinical criteria are to be employed. Such physicians must represent major areas of specialty and be certified by the boards of the American Board of Medical Specialties or the American Osteopathic Association. The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall seek input from physicians who are not employees of the medicare administrative con-

tractor, Medicare Advantage plan, or prescription drug plan.

(4) WRITTEN CLINICAL CRITERIA.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall apply written clinical criteria for the purpose of preauthorization review consistently. Such written clinical criteria must—

(A) be based on nationally recognized standards;

(B) be developed in accordance with the current standards of national accreditation entities;

(C) reflect community standards of care;

(D) ensure quality of care and access to needed health care services;

(E) be evidence based;

(F) be sufficiently flexible to allow deviations from norms when justified on case-by-case bases; and

(G) be evaluated and updated if necessary at least annually.

(5) WEBSITE POSTING.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall make any cur-

rent preauthorization requirements and restrictions readily accessible on its website to subscribers, health care providers, and the general public. This includes the written clinical criteria. Such requirements must be described in detail but also in easily understandable language.

(6) NOTICE REQUIRED FOR NEW REQUIREMENTS OR RESTRICTIONS.—If the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, decides to implement a new preauthorization requirement or restriction, or amend an existing requirement or restriction, the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall provide contracted health care providers written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented and shall ensure that the new or amended requirement has been updated on the medicare administrative contractor, Medicare Advantage plan, or prescription drug plan's website.

(7) AVAILABILITY OF DETERMINATIONS.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, utilizing preauthorization shall make statistics avail-

able regarding preauthorization approvals and denials for coverage or payment of health care services under the Medicare program under title XVIII of the Social Security Act or such plan on their website in a readily accessible format. The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan shall include categories for—

(A) physician specialty;

(B) medication or diagnostic test/procedure;

(C) indication offered; and

(D) reason for denial.

(8) DETERMINATIONS MADE BY PHYSICIANS.—The medicare administrative contractor, Medicare Advantage plan, or prescription drug plan, respectively, shall ensure that all preauthorizations and adverse determinations are made by a physician who possesses a current and valid non-restricted license to practice medicine in a State, and must be board certified or eligible under the rules and guidelines of the American Board of Medical Specialties or American Osteopathic Association in the same specialty as the health care provider who typically manages the medical condition or disease or provides the health care service. The physician must make the

adverse determination under the clinical direction of one of the medicare administrative contractor's, Medicare Advantage plan's, or prescription drug plan's medical directors who is responsible for the provision of health care services and who is licensed in such State.

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