

## **H.R. 3173, Medicare Prior Authorization**

Insurers offering Medicare Advantage plans requiring prior authorization would have to establish an electronic authorization program and meet new standards for decision timing and transparency under a modified version of H.R. 3173.

The Health and Human Services Department would have to approve the electronic authorization programs and would also set time frames and transparency requirements for prior authorization decisions for Medicare Advantage plans.

Medicare Advantage plans allow individuals to obtain coverage normally provided through Part A (hospital) and Part B (medically necessary and preventive services) from approved private insurers.

MA plans, like other insurance plans, often require health care providers to obtain prior authorization for certain medical treatments before they can treat patients. In a September 2018 report, HHS' Office of Inspector General found that MA plans overturned 75% of their denials for preauthorization — raising concerns that some MA beneficiaries and providers were initially denied services and payments that were medically necessary.

“When seniors need critical medical care, doctors and other health care providers should be spending their time working with patients instead of going back and forth on requests that should be electronic, standardized, and eventually automated,” said bill sponsor Rep. Suzan DelBene (D-Wash.) in a May 2021 news release. The bill would create “sensible rules for the road and will offer transparency and oversight to the prior authorization process,” she added.

HHS would have to provide for the transfer of \$15 million from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare and Medicaid Services Program Management Account for fiscal 2022 to carry out the measure.

## Prior Authorization Requirements

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Medicare Advantage insurers that impose prior authorization requirements would have to establish an electronic preauthorization program within three plan years of the bill's enactment that would provide:

- Real-time decisions if the request is submitted with the documentation required by an MA plan.
- Secure electronic transmission of a request and any health claims attachment that comply with applicable technical standards set by HHS and any other requirements to promote the standardization and streamlining of electronic transactions. A fax, electronic form, or proprietary payer portal that doesn't meet HHS standards wouldn't be treated as an electronic transmission.

HHS would have to announce the items and services for which prior authorization requests are regularly approved and update the list at least every two years.

HHS would also have to conduct a rulemaking to determine what constitutes a real-time decision based on current medical practice, technology, and health care industry standards — though it could be no longer than seven days after a prior authorization request.

MA insurers could request a delay in issuing a real-time decision on a prior authorization request of as long as 72 hours after receiving the request, or 24 hours in cases where a delay could seriously jeopardize a beneficiary's life, .

The department would have to finalize any additional requirements to streamline electronic transmission by July 1, 2023.

## Other Provisions

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**Transparency:** The measure would require MA plans to annually submit to HHS a list of the items and services that required prior authorization in the previous plan year.

Plans would also be required to provide information on preauthorization requests submitted, approved or denied as well as decisions that were delayed or appealed.

The bill would also direct plans to submit information on:

- The average and median time between a request and a decision.

- Information on when medical professionals, in the course of providing previously authorized surgery or services, must seek additional prior authorization.
- Artificial intelligence, machine learning, or any technology specified by the HHS the plan used to make decisions.
- Grievances received related to a prior authorization requirement.

The measure would allow MA plans to offer additional information on the percentage and number of requests denied because they didn't demonstrate that a patient met specified clinical criteria for items and services.

Plans would also have to provide their policies on prior authorization requests and criteria used to make prior authorization decisions to health care providers or suppliers seeking to contract with the plan. Enrollees could also request decision-making criteria. HHS would have to publish all prior authorization data and decision-making criteria on the Centers for Medicare and Medicaid Services website broken down by individual plan levels.

MA plans would have to comply with transparency requirements within four plan years of the bill's enactment.

Enrollee Protection: The bill would direct HHS to conduct a rulemaking to set requirements for Medicare Advantages plans to ensure they:

- Adopt transparent prior authorization programs developed in consultation with enrollees and participating health-care providers.
- Allow for waivers or modifications of preauthorization requirements based on provider compliance with evidence-based medical guidelines.
- Annually review the items and services for which it requires prior authorization while considering stakeholder input.

MedPAC Report: The Medicare Payment Advisory Commission would have to report to Congress with an analysis of the use of prior authorization, including relevant statistics on appeals and overturned decisions and recommendations to improve electronic preauthorization programs.

## **Group Positions**

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The bill is SUPPORTED by 500 organizations, including AAHAM, AARP, American Medical Association, Better Medicare Alliance, and the Regulatory Relief Coalition.

## **Previous Actions**

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DelBene introduced the bill, called the “Improving Seniors’ Timely Access to Care Act,” on May 13, 2021. It had 311 cosponsors, including 180 Democrats and 131 Republicans, as of Sept. 12.

The bill was referred to the House Ways and Means and the Energy and Commerce committees, which haven’t considered it, though the Energy and Commerce Subcommittee on Health plans to hold a markup Sept. 14.

The Ways and Means panel approved a similar bill (H.R. 8487) — also introduced by DelBene — by voice vote on July 27. The version of H.R. 3173 reflects what was approved by the committee.

Sen. Roger Marshall (R-Kan.) introduced a companion (S. 3018) to H.R. 3173 in October 2021 that was cosponsored by 21 Democrats and 19 Republicans as of Sept. 12. The Senate Finance Committee hasn’t acted on the measure.

## **Prospects**

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House leaders listed H.R. 3173 for consideration as soon as Sept. 14 under suspension of the rules. A two-thirds majority would be required for passage.