

119TH CONGRESS  
1ST SESSION

# H. R. 2433

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

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## 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.

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 “Reducing Medically  
5 Unnecessary Delays in Care Act of 2025”.

6 **SEC. 2. DEFINITIONS.**

7 In this Act:

1           (1) ADVERSE DETERMINATION.—The term “ad-  
2           verse determination” means a decision by a medicare  
3           administrative contractor, Medicare Advantage plan,  
4           or prescription drug plan that administers prior au-  
5           thorization programs under the Medicare program  
6           under title XVIII of the Social Security Act or such  
7           plan that the health care services furnished or pro-  
8           posed to be furnished to an individual entitled to  
9           benefits or enrolled under the Medicare program are  
10          not medically necessary, or are experimental or in-  
11          vestigational; and benefit coverage under such pro-  
12          gram or plan for such services is therefore denied,  
13          reduced, or terminated.

14          (2) AUTHORIZATION.—The term “authoriza-  
15          tion” means a determination by a medicare adminis-  
16          trative contractor, Medicare Advantage plan, or pre-  
17          scription drug plan that administers prior authoriza-  
18          tion programs under the Medicare program under  
19          title XVIII of the Social Security Act or such plan  
20          that a health care service has been reviewed and,  
21          based on the information provided, satisfies the utili-  
22          zation review entity’s requirements for medical ne-  
23          cessity and appropriateness and that payment will  
24          be made under the Medicare program under title

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

3 (3) CLINICAL CRITERIA.—The term “clinical  
4 criteria” means the written policies, written screen-  
5 ing procedures, drug formularies, or lists of covered  
6 drugs, decision rules, decision abstracts, clinical pro-  
7 tocols, practice guidelines, and medical protocols  
8 used by a medicare administrative contractor, Medi-  
9 care Advantage plan, or prescription drug plan to  
10 determine the necessity and appropriateness of  
11 health care services.

12 (4) FINAL ADVERSE DETERMINATION.—The  
13 term “final adverse determination” means an ad-  
14 verse determination that has been upheld by a medi-  
15 care administrative contractor, Medicare Advantage  
16 plan, or prescription drug plan at the completion of  
17 the contractor’s appeals process.

18 (5) HEALTH CARE SERVICE.—The term “health  
19 care service” means a health care item, service, pro-  
20 cedure, treatment, or prescription drug provided by  
21 a facility licensed in the State involved or provided  
22 by a doctor of medicine, a doctor of osteopathic med-  
23 icine, or a health care professional licensed in such  
24 State.

1           (6) MEDICALLY NECESSARY HEALTH CARE  
2 SERVICE.—The term “medically necessary health  
3 care services” means health care services that a pru-  
4 dent physician would provide to a patient for the  
5 purpose of preventing, diagnosing, or treating an ill-  
6 ness, injury, disease, or its symptoms in a manner  
7 that is—

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

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

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

16           (7) MEDICARE ADMINISTRATIVE CON-  
17 TRACTOR.—The term “medicare administrative con-  
18 tractor” means a medicare administrative contractor  
19 with a contract under section 1874A of the Social  
20 Security Act (42 U.S.C. 1395kk–1).

21           (8) MEDICARE ADVANTAGE PLAN.—The term  
22 “Medicare Advantage plan” means a Medicare Ad-  
23 vantage plan under part C of title XVIII of the So-  
24 cial Security Act.

1           (9)        PREAUTHORIZATION.—The        term  
2        “preauthorization”—

3                   (A) means the process by which a medicare  
4        administrative contractor, Medicare Advantage  
5        plan, or prescription drug plan determines the  
6        medical necessity or medical appropriateness of  
7        health care services for which benefits are oth-  
8        erwise provided under the Medicare program  
9        under title XVIII of the Social Security Act or  
10       such plan prior to the rendering of such health  
11       care services, including preadmission review,  
12       pretreatment review, utilization, and case man-  
13       agement; and

14                   (B) includes any requirement that a pa-  
15        tient or health care provider notify the Centers  
16        for Medicare & Medicaid Services prior to pro-  
17        viding a health care service.

18           (10) PRESCRIPTION DRUG PLAN.—The term  
19        “prescription drug plan” means a prescription drug  
20        plan under part D of title XVIII of the Social Secu-  
21        rity Act.

1 **SEC. 3. CONTRACT REQUIREMENTS FOR PRIOR AUTHOR-**  
2 **IZATION MEDICAL DECISIONS FOR MEDI-**  
3 **CARE ADMINISTRATIVE CONTRACTORS,**  
4 **MEDICARE ADVANTAGE PLANS, AND PRE-**  
5 **SCRIPTION DRUG PLANS.**

6 Any contract that applies on or after the date that  
7 is 90 days after the date of the enactment of this Act,  
8 between the Secretary of Health and Human Services and  
9 a medicare administrative contractor under section 1874A  
10 of the Social Security Act, a Medicare Advantage organi-  
11 zation under section 1857 of such Act with respect to the  
12 offering of a Medicare Advantage plan, or a PDP sponsor  
13 under section 1860D–12 of such Act with respect to the  
14 offering of a prescription drug plan shall require such  
15 medicare administrative contractor, Medicare Advantage  
16 plan, or prescription drug plan, respectively, to comply  
17 with each of the following requirements:

18 (1) **MEDICAL NECESSITY.**—Any restriction,  
19 preauthorization, adverse determination, or final ad-  
20 verse determination that the medicare administrative  
21 contractor, Medicare Advantage plan, or prescription  
22 drug plan, respectively, places on the provision of a  
23 health care service for the purposes of coverage or  
24 payment of such service under the Medicare pro-  
25 gram under title XVIII of such Act, or under such  
26 plan, shall be based on the medical necessity or ap-

1       appropriateness of such service and on written clinical  
2       criteria.

3               (2) EVIDENCE-BASED STANDARDS.—If no inde-  
4       pendently developed evidence-based standards exist  
5       for a particular health care service, the medicare ad-  
6       ministrative contractor, Medicare Advantage plan, or  
7       prescription drug plan, respectively, may not deny  
8       coverage of the health care service based solely on  
9       the grounds that the health care service does not  
10      meet an evidence-based standard.

11              (3) INPUT FROM PHYSICIANS.—Prior to estab-  
12      lishing, or substantially or materially altering, writ-  
13      ten clinical criteria for purpose of preauthorization  
14      review, the medicare administrative contractor,  
15      Medicare Advantage plan, or prescription drug plan,  
16      respectively, shall obtain input from actively prac-  
17      ticing physicians within the service area where the  
18      written clinical criteria are to be employed. Such  
19      physicians must represent major areas of specialty  
20      and be certified by the boards of the American  
21      Board of Medical Specialties or the American Osteo-  
22      pathic Association. The medicare administrative con-  
23      tractor, Medicare Advantage plan, or prescription  
24      drug plan shall seek input from physicians who are  
25      not employees of the medicare administrative con-

1 tractor, Medicare Advantage plan, or prescription  
2 drug plan.

3 (4) WRITTEN CLINICAL CRITERIA.—The medi-  
4 care administrative contractor, Medicare Advantage  
5 plan, or prescription drug plan, respectively, shall  
6 apply written clinical criteria for the purpose of  
7 preauthorization review consistently. Such written  
8 clinical criteria must—

9 (A) be based on nationally recognized  
10 standards;

11 (B) be developed in accordance with the  
12 current standards of national accreditation enti-  
13 ties;

14 (C) reflect community standards of care;

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

17 (E) be evidence based;

18 (F) be sufficiently flexible to allow devi-  
19 ations from norms when justified on case-by-  
20 case bases; and

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

23 (5) WEBSITE POSTING.—The medicare adminis-  
24 trative contractor, Medicare Advantage plan, or pre-  
25 scription drug plan, respectively, shall make any cur-

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

7               (6) NOTICE REQUIRED FOR NEW REQUIRE-  
8       MENTS OR RESTRICTIONS.—If the medicare adminis-  
9       trative contractor, Medicare Advantage plan, or pre-  
10      scription drug plan, respectively, decides to imple-  
11      ment a new preauthorization requirement or restric-  
12      tion, or amend an existing requirement or restric-  
13      tion, the medicare administrative contractor, Medi-  
14      care Advantage plan, or prescription drug plan shall  
15      provide contracted health care providers written no-  
16      tice of the new or amended requirement or amend-  
17      ment no less than 60 days before the requirement or  
18      restriction is implemented and shall ensure that the  
19      new or amended requirement has been updated on  
20      the medicare administrative contractor, Medicare  
21      Advantage plan, or prescription drug plan’s website.

22              (7) AVAILABILITY OF DETERMINATIONS.—The  
23      medicare administrative contractor, Medicare Advan-  
24      tage plan, or prescription drug plan, respectively,  
25      utilizing preauthorization shall make statistics avail-

1 able regarding preauthorization approvals and deni-  
2 als for coverage or payment of health care services  
3 under the Medicare program under title XVIII of  
4 the Social Security Act or such plan on their website  
5 in a readily accessible format. The medicare admin-  
6 istrative contractor, Medicare Advantage plan, or  
7 prescription drug plan shall include categories for—

8 (A) physician specialty;

9 (B) medication or diagnostic test/proce-  
10 dure;

11 (C) indication offered; and

12 (D) reason for denial.

13 (8) DETERMINATIONS MADE BY PHYSICIANS.—

14 The medicare administrative contractor, Medicare  
15 Advantage plan, or prescription drug plan, respec-  
16 tively, shall ensure that all preauthorizations and ad-  
17 verse determinations are made by a physician who  
18 possesses a current and valid non-restricted license  
19 to practice medicine in a State, and must be board  
20 certified or eligible under the rules and guidelines of  
21 the American Board of Medical Specialties or Amer-  
22 ican Osteopathic Association in the same specialty  
23 as the health care provider who typically manages  
24 the medical condition or disease or provides the  
25 health care service. The physician must make the

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

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