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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

Mr. LANDSMAN introduced the following bill; which was referred to the Committee on _____

A BILL

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

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 ''Protecting Approved Care Act''.

SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION AND CLAIMS DENIAL UNDER MEDICARE ADVANTAGE PLAN.

Section 1857(e) of the Social Security Act (42 U.S.C. 1395e–27(e)) is amended by adding at the end the following new paragraph:

''(7) LIMITATIONS ON CLAIMS DENIAL FOR COVERED ITEMS AND SERVICES.—

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2028, a contract under this section with an MA organization shall require that—

''(i) in the case that the MA organization approves the furnishing to an individual enrolled under an MA plan offered by such MA organization of an item or service through a specified authorization made during the receipt by the individual of such item or service, the MA organization may not, after such approval, take any of the actions described in subparagraph (B) with respect to such item or service; and

''(ii) in the case that there is no requirement to obtain a specified authoriza-

tion with respect to an item or service for which benefits are available under the plan, the MA organization may not, after an individual enrolled under such plan receives such item or service, take any of the actions described in subparagraph (B) with respect to such item or service.

''(B) ACTIONS DESCRIBED.—For purposes of subparagraph (A), the actions described in this subparagraph are, with respect to an MA organization and an item or service, the following:

''(i) Denying coverage of such item or service on the basis of lack of medical necessity.

''(ii) Reopening a determination of coverage or payment made with respect to such item or service (including a specified authorization) for any reason other than—

''(I) good cause (as described in sections 405.986 and 422.616 of title 42, Code of Federal Regulations (or any successor regulation)); or

''(II) reliable evidence of fraud or similar fault (as such terms are de-

fined in section 405.902 of such title (or any successor regulation)), as determined in accordance with section 422.616 of such title (or any successor regulation).

''(iii) Changing the code assigned with respect to the claim for such item or service such that the amount of payment for such claim would be reduced, except for good cause (as described in clause (ii)) or if there is reliable evidence of fraud or similar fault (as so described).

''(C) SPECIFIED AUTHORIZATION DEFINED.—In this paragraph, the term 'specified authorization'—

''(i) means, with respect to an individual enrolled under an MA plan offered by a Medicare Advantage organization, an authorization of coverage or payment for an item or service through—

''(I) a prior authorization or preservice determination of coverage or payment; or

''(II) a concurrent determination made while the individual is receiving the relevant item or service; and

''(ii) includes an authorization for a transfer of the individual between hospitals or between a hospital and post-acute care facility.''.