

119TH CONGRESS
2D SESSION

H. R. 10394

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

SEPTEMBER 15, 2026

Mr. LANDSMAN (for himself and Mr. ONDER) 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

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.

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 “Protecting Approved
5 Care Act”.

1 **SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO**
2 **THE USE OF PRIOR AUTHORIZATION AND**
3 **CLAIMS DENIAL UNDER MEDICARE ADVAN-**
4 **TAGE PLAN.**

5 Section 1857(e) of the Social Security Act (42 U.S.C.
6 1395e–27(e)) is amended by adding at the end the fol-
7 lowing new paragraph:

8 “(7) LIMITATIONS ON CLAIMS DENIAL FOR COV-
9 ERED ITEMS AND SERVICES.—

10 “(A) IN GENERAL.—Beginning with plan
11 years beginning on or after January 1, 2028, a
12 contract under this section with an MA organi-
13 zation shall require that—

14 “(i) in the case that the MA organiza-
15 tion approves the furnishing to an indi-
16 vidual enrolled under an MA plan offered
17 by such MA organization of an item or
18 service through a specified authorization
19 made during the receipt by the individual
20 of such item or service, the MA organiza-
21 tion may not, after such approval, take any
22 of the actions described in subparagraph
23 (B) with respect to such item or service;
24 and

25 “(ii) in the case that there is no re-
26 quirement 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-

1 fined in section 405.902 of such title
2 (or any successor regulation)), as de-
3 termined in accordance with section
4 422.616 of such title (or any suc-
5 cessor regulation).

6 “(iii) Changing the code assigned with
7 respect to the claim for such item or serv-
8 ice such that the amount of payment for
9 such claim would be reduced, except for
10 good cause (as described in clause (ii)) or
11 if there is reliable evidence of fraud or
12 similar fault (as so described).

13 “(C) SPECIFIED AUTHORIZATION DE-
14 FINED.—In this paragraph, the term ‘specified
15 authorization’—

16 “(i) means, with respect to an indi-
17 vidual enrolled under an MA plan offered
18 by a Medicare Advantage organization, an
19 authorization of coverage or payment for
20 an item or service through—

21 “(I) a prior authorization or
22 preservice determination of coverage
23 or payment; or

1 “(II) a concurrent determination
2 made while the individual is receiving
3 the relevant item or service; and

4 “(ii) includes an authorization for a
5 transfer of the individual between hospitals
6 or between a hospital and post-acute care
7 facility.”.

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