

May 30, 2025: National Advocacy Update



Bipartisan AMA-supported prior authorization legislation reintroduced in Congress

A bipartisan collection of senators and representatives reintroduced on May 20 important legislation that mandates that health plans in Medicare Advantage (MA) meet federally developed electronic prior authorization (e-PA) standards, as well as comply with more stringent transparency requirements.

Senators Roger Marshall, MD (R-KS) and Mark Warner (D-VA), along with Representatives Mike Kelly (R-PA), Suzan DelBene (D-WA), John Joyce, MD (R-PA) and Ami Bera, MD (D-CA), will serve as the bipartisan, bicameral lead sponsors of the Improving Seniors' Timely Access to Care Act in the 119th Congress.

While a full section-by-section analysis of the legislation can be found [online](#) (PDF), the legislation would:

- Establish an electronic prior authorization process for MA plans including standardization for transactions and clinical attachments.
 - Faxes, e-forms, or proprietary web portals run by health plans that do not meet these standards would not qualify as secure electronic transmissions.
- Increase transparency around MA prior authorization and its use.
 - Health plans would now be required to, among other things, report on all items and services subjected to e-PA requirements the previous plan year, the percent and number of requests approved and denied, the percent and number of requests approved or denied utilizing artificial intelligence or machine learning technology, and the average and median amount of time (in hours) that elapsed between the time the request was submitted and when the health plan issued a final decision.
- Clarify HHS' authority to establish timeframes for electronic prior authorization requests, including expedited timelines for determinations, as well as real-time decisions for routinely approved items, services, and other prior authorization requests.
 - The bill, however, does not mandate any specific deadlines for health plans to issue final decisions on prior authorization requests in order to avoid triggering any costs via a Congressional Budget Office (CBO) analysis often referred to as a "score."
- Expand beneficiary protections to improve enrollee experiences and outcomes, including allowing for the waiver or modification of PA requirements for contracted providers and suppliers based on past performance and adherence to evidence-based medical guidelines



(i.e., Gold Card programs).

- Require HHS and other agencies report to Congress on program integrity efforts and other ways to further improve the electronic prior authorization process.

The Improving Seniors' Timely Access to Care Act remains a key pillar of AMA's overarching advocacy campaign focused on reforming prior authorization requirements. Previous versions of the legislation passed out of key committees of jurisdiction and the full House of Representatives in the 118th and 117th Congresses, respectively. The legislation continues to generate broad support from all parts of the health care system, including hospitals, physicians, allied health professionals, patient organizations, and even insurers.

As of May 27, the legislation already garnered tremendous bipartisan congressional support, specifically securing 49 Senate and 77 House cosponsors. The AMA applauds the House and Senate lead sponsors and looks forward to working with bipartisan leadership in both chambers to expeditiously pass this crucial legislation that benefits both patients and physicians.

AMA to FDA: Protect patients with pain

The AMA last week urged (PDF) the U.S. Food and Drug Administration (FDA) to ensure that any future decisions do not arbitrarily restrict patients' access to care. This includes support for both pharmacologic and non-pharmacologic options that are based on the physician's best medical judgment and individualized patient characteristics. The AMA wrote following a recent joint meeting of the FDA drug safety and risk management advisory committee and the anesthetic and analgesic drug products advisory committee. At the meeting, some groups recommended that FDA impose strict opioid prescribing guidelines based on the 2016 CDC Clinical Practice Guideline for Prescribing Opioids, which were significantly revised in 2022 because of the 2016 guidelines' harmful consequences to patients with pain.

The AMA reminded FDA that the 2022 CDC revision made multiple critical revisions and clarifications to emphasize that the guideline "provides voluntary clinical practice recommendations for clinicians that should not be used as inflexible standards of care. The recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, health care systems, or government entities."

The AMA also stressed to FDA that the unintended consequences of the 2016 guideline continue to harm patients. In addition to the dozens of state laws, pharmacy policies and other arbitrary restrictions, there also continues to be nonconsensual tapering for individuals with chronic pain and refusals to fill prescriptions for individuals with cancer, sickle cell disease, in hospice or with palliative care needs. A recent study in JAMA Health Forum found that the 2016 Centers for Disease Control and Prevention guideline—which was not supposed to harm patients with cancer—had the effect of



patients receiving less effective pain care.

DOJ and FTC requests for information on deregulation

AMA responded (PDF) to recent requests for information (RFIs) from the U.S. Department of Justice (DOJ) Anticompetitive Regulations Task Force and the Federal Trade Commission (FTC) on regulations that are unnecessarily burdensome or impede competition in the health care industry. AMA highlighted its longstanding opposition to anticompetitive regulations in the health care sector, as detailed in its [2023](#) (PDF) and [2024](#) (PDF) letters to Congress and federal agencies. AMA's May 2025 RFI responses to DOJ and FTC further urged the administration to vigorously enforce policies that promote market competition and patient choice, including actions that support payment adequacy.

Both AMA RFI responses further urged the agencies to act on:

- Merit-based Incentive Payment System (MIPS) requirements
- Alternative Payment Models (APMs)
- Physician-owned hospitals (POHs)
- The Medicare Two-Midnight Rule
- Civil monetary penalties for information blocking
- Proposed revisions to the HIPAA Security Rule
- Stark law In-Office Ancillary Services requirements
- The No Surprises Act
- Exemptions for rural hospitals and critical access hospitals from the Obstetrical Services Conditions of Participation
- Step therapy
- Removing barriers to prescribing buprenorphine for opioid use disorder treatment
- Strengthening transparency and preventing arbitrary Medicare payment changes
- Protecting equitable patient access to care

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