

119TH CONGRESS
2D SESSION

H. R. 9396

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require the displaying of claim denial rates.

IN THE HOUSE OF REPRESENTATIVES

JUNE 23, 2026

Mr. GOLDMAN of Texas introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Workforce, 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 XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require the displaying of claim denial rates.

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 “Prior Authorization
5 Accountability Act”.

1 **SEC. 2. DISPLAYING CLAIM DENIAL RATES.**

2 (a) PHSA.—Part D of title XXVII of the Public
3 Health Service Act (42 U.S.C. 300gg–111 et seq.) is
4 amended by adding at the end the following new section:

5 **“SEC. 2799A–12. PRIOR AUTHORIZATION TRANSPARENCY**
6 **REQUIREMENTS.**

7 “(a) IN GENERAL.—In the case of a group health
8 plan or health insurance issuer offering group or indi-
9 vidual health insurance coverage that imposes any prior
10 authorization requirement with respect to an item or serv-
11 ice furnished under such plan or coverage during a plan
12 year beginning on or after January 1, 2027, such plan
13 or issuer shall, at a time and in a manner specified by
14 the Secretary, submit to the Secretary (and, in the case
15 of group or individual health insurance coverage, if such
16 coverage was offered through an Exchange established
17 under subtitle D of title I of the Patient Protection and
18 Affordable Care Act, to such Exchange) and make avail-
19 able on a public website of the plan or issuer the following
20 information:

21 “(1) A list of all items and services that were
22 subject to a prior authorization requirement under
23 the plan or coverage during such plan year.

24 “(2) The percentage and number of prior au-
25 thorization requests approved during such plan year
26 by the plan or issuer in an initial determination and

1 the percentage and number of prior authorization re-
2 quests denied during such plan year by such plan or
3 issuer in an initial determination (both in the aggre-
4 gate and categorized by each item and service).

5 “(3) The percentage and number of prior au-
6 thorization requests that were denied during such
7 plan year by the plan or issuer in an initial deter-
8 mination and that were subsequently appealed.

9 “(4) The percentage and number of resolved
10 appeals of such requests that resulted in approval of
11 the furnishing of the item or service that was the
12 subject of such request, categorized by each item
13 and service and categorized by each level of appeal
14 (including judicial review).

15 “(5) The average and the median amount of
16 time (in hours) that elapsed during such plan year
17 between the submission of a prior authorization re-
18 quest to the plan or issuer and a determination by
19 the plan or issuer with respect to such request for
20 each such item and service, excluding any such re-
21 quests that were not submitted with the medical or
22 other documentation required to be submitted by the
23 plan or issuer.

24 “(6) The percentage and number of prior au-
25 thorization requests that were denied, and the per-

1 centage and number of prior authorization requests
2 that were approved, by the plan or issuer during
3 such plan year solely through the utilization of deci-
4 sion support technology, artificial intelligence tech-
5 nology, machine-learning technology, clinical deci-
6 sion-making technology, or any other technology
7 specified by the Secretary.

8 “(7) A disclosure and description of any tech-
9 nology described in paragraph (6) that the plan or
10 issuer utilized during such plan year in making de-
11 terminations with respect to prior authorization re-
12 quests.

13 “(b) MANNER OF PUBLICATION.—Information sub-
14 mitted and published by a group health plan or health in-
15 surance issuer offering group or individual health insur-
16 ance coverage under subsection (a) shall be so submitted
17 and published on a group health plan and health insurance
18 coverage level and shall in addition, if determined appro-
19 priate by the Secretary, be so submitted and published in
20 the aggregate in such manner as specified by the Sec-
21 retary (such as across all group health plans of the spon-
22 sor of such plan or all health insurance coverage offered
23 by such issuer that are offered within the same insurance
24 market (as specified in subclause (I), (II), (III), or (IV)
25 of section 2799A–1(a)(3)(E)(iv))).”.

1 (b) ERISA.—

2 (1) IN GENERAL.—Subpart B of part 7 of sub-
3 title B of title I of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1185 et seq.) is
5 amended by adding at the end the following new sec-
6 tion:

7 **“SEC. 727. PRIOR AUTHORIZATION TRANSPARENCY RE-**
8 **QUIREMENTS.**

9 “(a) IN GENERAL.—In the case of a group health
10 plan or health insurance issuer offering group health in-
11 surance coverage that imposes any prior authorization re-
12 quirement with respect to an item or service furnished
13 under such plan or coverage during a plan year beginning
14 on or after January 1, 2027, such plan or issuer shall,
15 at a time and in a manner specified by the Secretary, sub-
16 mit to the Secretary and make available on a public
17 website of the plan or issuer the following information:

18 “(1) A list of all items and services that were
19 subject to a prior authorization requirement under
20 the plan or coverage during such plan year.

21 “(2) The percentage and number of prior au-
22 thorization requests approved during such plan year
23 by the plan or issuer in an initial determination and
24 the percentage and number of prior authorization re-
25 quests denied during such plan year by such plan or

1 issuer in an initial determination (both in the aggre-
2 gate and categorized by each item and service).

3 “(3) The percentage and number of prior au-
4 thorization requests that were denied during such
5 plan year by the plan or issuer in an initial deter-
6 mination and that were subsequently appealed.

7 “(4) The percentage and number of resolved
8 appeals of such requests that resulted in approval of
9 the furnishing of the item or service that was the
10 subject of such request, categorized by each item
11 and service and categorized by each level of appeal
12 (including judicial review).

13 “(5) The average and the median amount of
14 time (in hours) that elapsed during such plan year
15 between the submission of a prior authorization re-
16 quest to the plan or issuer and a determination by
17 the plan or issuer with respect to such request for
18 each such item and service, excluding any such re-
19 quests that were not submitted with the medical or
20 other documentation required to be submitted by the
21 plan or issuer.

22 “(6) The percentage and number of prior au-
23 thorization requests that were denied, and the per-
24 centage and number of prior authorization requests
25 that were approved, by the plan or issuer during

1 such plan year solely through the utilization of deci-
2 sion support technology, artificial intelligence tech-
3 nology, machine-learning technology, clinical deci-
4 sion-making technology, or any other technology
5 specified by the Secretary.

6 “(7) A disclosure and description of any tech-
7 nology described in paragraph (6) that the plan or
8 issuer utilized during such plan year in making de-
9 terminations with respect to prior authorization re-
10 quests.

11 “(b) MANNER OF PUBLICATION.—Information sub-
12 mitted and published by a group health plan or health in-
13 surance issuer offering group health insurance coverage
14 under subsection (a) shall be so submitted and published
15 on a group health plan and health insurance coverage level
16 and shall in addition, if determined appropriate by the
17 Secretary, be so submitted and published in the aggregate
18 in such manner as specified by the Secretary (such as
19 across all group health plans of the sponsor of such plan
20 or all health insurance coverage offered by such issuer that
21 are offered within the same insurance market (as specified
22 in subclause (I), (II), (III), or (IV) of section
23 716(a)(3)(E)(iv)).”.

24 (2) CLERICAL AMENDMENT.—The table of con-
25 tents in section 1 of the Employee Retirement In-

1 come Security Act of 1974 (29 U.S.C. 1001 note) is
 2 amended by inserting after the item relating to sec-
 3 tion 726 the following new item:

“Sec. 727. Prior authorization transparency requirements.”.

4 (c) IRC.—

5 (1) IN GENERAL.—Subchapter B of chapter
 6 100 of the Internal Revenue Code of 1986 is amend-
 7 ed by adding at the end the following new section:

8 **“SEC. 9827. PRIOR AUTHORIZATION TRANSPARENCY RE-**
 9 **QUIREMENTS.**

10 “(a) IN GENERAL.—In the case of a group health
 11 plan that imposes any prior authorization requirement
 12 with respect to an item or service furnished under such
 13 plan during a plan year beginning on or after January
 14 1, 2027, such plan shall, at a time and in a manner speci-
 15 fied by the Secretary, submit to the Secretary and make
 16 available on a public website of the plan the following in-
 17 formation:

18 “(1) A list of all items and services that were
 19 subject to a prior authorization requirement under
 20 the plan during such plan year.

21 “(2) The percentage and number of prior au-
 22 thorization requests approved during such plan year
 23 by the plan in an initial determination and the per-
 24 centage and number of prior authorization requests
 25 denied during such plan year by such plan in an ini-

1 tial determination (both in the aggregate and cat-
2 egorized by each item and service).

3 “(3) The percentage and number of prior au-
4 thorization requests that were denied during such
5 plan year by the plan in an initial determination and
6 that were subsequently appealed.

7 “(4) The percentage and number of resolved
8 appeals of such requests that resulted in approval of
9 the furnishing of the item or service that was the
10 subject of such request, categorized by each item
11 and service and categorized by each level of appeal
12 (including judicial review).

13 “(5) The average and the median amount of
14 time (in hours) that elapsed during such plan year
15 between the submission of a prior authorization re-
16 quest to the plan and a determination by the plan
17 with respect to such request for each such item and
18 service, excluding any such requests that were not
19 submitted with the medical or other documentation
20 required to be submitted by the plan.

21 “(6) The percentage and number of prior au-
22 thorization requests that were denied, and the per-
23 centage and number of prior authorization requests
24 that were approved, by the plan during such plan
25 year solely through the utilization of decision sup-

1 port technology, artificial intelligence technology,
2 machine-learning technology, clinical decision-mak-
3 ing technology, or any other technology specified by
4 the Secretary.

5 “(7) A disclosure and description of any tech-
6 nology described in paragraph (6) that the plan uti-
7 lized during such plan year in making determina-
8 tions with respect to prior authorization requests.

9 “(b) MANNER OF PUBLICATION.—Information sub-
10 mitted and published by a group health plan under sub-
11 section (a) shall be so published on a group health plan
12 level and shall in addition, if determined appropriate by
13 the Secretary, be so submitted and published in the aggre-
14 gate in such manner as specified by the Secretary (such
15 as across all group health plans of the sponsor of such
16 plan that are offered within the same insurance market
17 (as specified in subclause (I), (II), (III), or (IV) of section
18 9816(a)(3)(E)(iv))).”.

19 (2) CLERICAL AMENDMENT.—The table of sec-
20 tions for subchapter B of chapter 100 of the Inter-
21 nal Revenue Code of 1986 is amended by adding at
22 the end the following new item:

“Sec. 9827. Prior authorization transparency requirements.”.

1 **SEC. 3. PROMOTING COMPARABILITY OF QUALIFIED**
2 **HEALTH PLANS OFFERED THROUGH AN EX-**
3 **CHANGE.**

4 Section 1311(d)(4)(C) of the Patient Protection and
5 Affordable Care Act (42 U.S.C. 18031(d)(4)(C)) is
6 amended—

7 (1) by striking “website through which” and in-
8 serting the following: “website—

9 “(i) through which”;

10 (2) in clause (i), as so inserted, by striking the
11 semicolon and inserting “; and”; and

12 (3) by adding at the end the following new
13 clause:

14 “(ii) that includes, as part of such
15 comparative information for enrollments
16 for plan years beginning on or after Janu-
17 ary 1, 2029, in the case a qualified health
18 plan offered through such Exchange for
19 such plan year was offered through such
20 Exchange for a previous plan year, the
21 most recent information submitted to such
22 Exchange with respect to such plan by the
23 health insurance issuer of such plan under
24 section 2799A–12 of the Public Health
25 Service Act;”.

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