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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. _____

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

Mr. GOLDMAN of Texas introduced the following bill; which was referred to the Committee on _____

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.

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 ''Prior Authorization Accountability Act''.

SEC. 2. DISPLAYING CLAIM DENIAL RATES.

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

"SEC. 2799A–12. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.

"(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that imposes any prior authorization requirement with respect to an item or service furnished under such plan or coverage during a plan year beginning on or after January 1, 2027, such plan or issuer shall, at a time and in a manner specified by the Secretary, submit to the Secretary (and, in the case of group or individual health insurance coverage, if such coverage was offered through an Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act, to such Exchange) and make available on a public website of the plan or issuer the following information:

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

"(2) The percentage and number of prior authorization requests approved during such plan year by the plan or issuer in an initial determination and

the percentage and number of prior authorization requests denied during such plan year by such plan or issuer in an initial determination (both in the aggregate and categorized by each item and service).

''(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan or issuer in an initial determination and that were subsequently appealed.

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

''(5) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan or issuer and a determination by the plan or issuer with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan or issuer.

''(6) The percentage and number of prior authorization requests that were denied, and the per-

centage and number of prior authorization requests that were approved, by the plan or issuer during such plan year solely through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(7) A disclosure and description of any technology described in paragraph (6) that the plan or issuer utilized during such plan year in making determinations with respect to prior authorization requests.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan or health insurance issuer offering group or individual health insurance coverage under subsection (a) shall be so submitted and published on a group health plan and health insurance coverage level and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan or all health insurance coverage offered by such issuer that are offered within the same insurance market (as specified in subclause (I), (II), (III), or (IV) of section 2799A–1(a)(3)(E)(iv))).''.

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

"SEC. 727. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.

"(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group health insurance coverage that imposes any prior authorization requirement with respect to an item or service furnished under such plan or coverage during a plan year beginning on or after January 1, 2027, such plan or issuer shall, at a time and in a manner specified by the Secretary, submit to the Secretary and make available on a public website of the plan or issuer the following information:

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

"(2) The percentage and number of prior authorization requests approved during such plan year by the plan or issuer in an initial determination and the percentage and number of prior authorization requests denied during such plan year by such plan or

issuer in an initial determination (both in the aggregate and categorized by each item and service).

''(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan or issuer in an initial determination and that were subsequently appealed.

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

''(5) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan or issuer and a determination by the plan or issuer with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan or issuer.

''(6) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests that were approved, by the plan or issuer during

such plan year solely through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(7) A disclosure and description of any technology described in paragraph (6) that the plan or issuer utilized during such plan year in making determinations with respect to prior authorization requests.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan or health insurance issuer offering group health insurance coverage under subsection (a) shall be so submitted and published on a group health plan and health insurance coverage level and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan or all health insurance coverage offered by such issuer that are offered within the same insurance market (as specified in subclause (I), (II), (III), or (IV) of section 716(a)(3)(E)(iv))).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement In-

come Security Act of 1974 (29 U.S.C. 1001 note) is amended by inserting after the item relating to section 726 the following new item:

"Sec. 727. Prior authorization transparency requirements.".

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9827. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.

"(a) IN GENERAL.—In the case of a group health plan that imposes any prior authorization requirement with respect to an item or service furnished under such plan during a plan year beginning on or after January 1, 2027, such plan shall, at a time and in a manner specified by the Secretary, submit to the Secretary and make available on a public website of the plan the following information:

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

"(2) The percentage and number of prior authorization requests approved during such plan year by the plan in an initial determination and the percentage and number of prior authorization requests denied during such plan year by such plan in an ini-

tial determination (both in the aggregate and categorized by each item and service).

''(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan in an initial determination and that were subsequently appealed.

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

''(5) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan.

''(6) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests that were approved, by the plan during such plan year solely through the utilization of decision sup-

port technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(7) A disclosure and description of any technology described in paragraph (6) that the plan utilized during such plan year in making determinations with respect to prior authorization requests.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan under subsection (a) shall be so published on a group health plan level and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan that are offered within the same insurance market (as specified in subclause (I), (II), (III), or (IV) of section 9816(a)(3)(E)(iv))).''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9827. Prior authorization transparency requirements.''.

SEC. 3. PROMOTING COMPARABILITY OF QUALIFIED HEALTH PLANS OFFERED THROUGH AN EXCHANGE.

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

(1) by striking ''website through which'' and inserting the following: ''website—

''(i) through which'';

(2) in clause (i), as so inserted, by striking the semicolon and inserting ''; and''; and

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

''(ii) that includes, as part of such comparative information for enrollments for plan years beginning on or after January 1, 2029, in the case a qualified health plan offered through such Exchange for such plan year was offered through such Exchange for a previous plan year, the most recent information submitted to such Exchange with respect to such plan by the health insurance issuer of such plan under section 2799A–12 of the Public Health Service Act;''.