

[DISCUSSION DRAFT]

119<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R.** \_\_\_\_\_

To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to require the displaying of claim denial rates.

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IN THE HOUSE OF REPRESENTATIVES

M. \_\_\_\_\_ introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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**A BILL**

To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act 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. DISPLAYING CLAIM DENIAL RATES.**

4 (a) **MEDICARE ADVANTAGE.**—Section 1852 of the  
5 Social Security Act (42 U.S.C. 1395w–22) is amended by  
6 adding at the end the following new subsection:

7 “(o) **PRIOR AUTHORIZATION TRANSPARENCY RE-**  
8 **QUIREMENTS.**—

1           “(1) IN GENERAL.—In the case of a Medicare  
2           Advantage plan that imposes any prior authorization  
3           requirement with respect to an item or service dur-  
4           ing a plan year beginning on or after January 1,  
5           2027, such plan shall, at a time and in a manner  
6           specified by the Secretary, submit to the Secretary  
7           and make available on a public website of the plan  
8           the following information:

9                   “(A) A list of all items and services that  
10                   were subject to a prior authorization require-  
11                   ment under the plan during such plan year.

12                   “(B) The percentage and number of prior  
13                   authorization requests approved during such  
14                   plan year by the plan in an initial determina-  
15                   tion and the percentage and number of prior  
16                   authorization requests denied during such plan  
17                   year by such plan in an initial determination  
18                   (both in the aggregate and categorized by each  
19                   item and service).

20                   “(C) The percentage and number of prior  
21                   authorization requests that were denied during  
22                   such plan year by the plan in an initial deter-  
23                   mination and that were subsequently appealed.

24                   “(D) The percentage and number of re-  
25                   solved appeals of such requests that resulted in

1 approval of the furnishing of the item or service  
2 that was the subject of such request, cat-  
3 egorized by each item and service and cat-  
4 egorized by each level of appeal (including judi-  
5 cial review).

6 “(E) The average and the median amount  
7 of time (in hours) that elapsed during such plan  
8 year between the submission of a prior author-  
9 ization request to the plan and a determination  
10 by the plan with respect to such request for  
11 each such item and service, excluding any such  
12 requests that were not submitted with the med-  
13 ical or other documentation required to be sub-  
14 mitted by the plan.

15 “(2) PUBLICATION OF INFORMATION.—The  
16 Secretary shall publish information submitted under  
17 paragraph (1) on a public website of the Centers for  
18 Medicare & Medicaid Services. Such information  
19 shall be so published on an individual plan level and  
20 may in addition be aggregated in such manner as  
21 determined appropriate by the Secretary (such as  
22 across all Medicare Advantage plans offered by an  
23 MA organization).”.

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

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

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

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

23 “(2) The percentage and number of prior au-  
24 thorization requests approved during such plan year  
25 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 “(b) MANNER OF PUBLICATION.—Information sub-  
25 mitted and published by a group health plan or health in-

1 surance issuer offering group or individual health insur-  
2 ance coverage under subsection (a) shall be so submitted  
3 and published on a group health plan and health insurance  
4 coverage level and shall in addition, if determined appro-  
5 priate by the Secretary, be so submitted and published in  
6 the aggregate in such manner as specified by the Sec-  
7 retary (such as across all group health plans of the spon-  
8 sor of such plan or all health insurance coverage offered  
9 by such issuer that are offered within the same insurance  
10 market (as specified in subclause (I), (II), (III), or (IV)  
11 of section 2799A-1(a)(3)(E)(iv))).”.

12 (c) ERISA.—

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

18 **“SEC. 727. PRIOR AUTHORIZATION TRANSPARENCY RE-**  
19 **QUIREMENTS.**

20 “(a) IN GENERAL.—In the case of a group health  
21 plan or health insurance issuer offering group health in-  
22 surance coverage that imposes any prior authorization re-  
23 quirement with respect to an item or service furnished  
24 under such plan or coverage during a plan year beginning  
25 on or after January 1, 2027, such plan or issuer shall,

1 at a time and in a manner specified by the Secretary, sub-  
2 mit to the Secretary and make available on a public  
3 website of the plan or issuer the following information:

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

7 “(2) The percentage and number of prior au-  
8 thorization requests approved during such plan year  
9 by the plan or issuer in an initial determination and  
10 the percentage and number of prior authorization re-  
11 quests denied during such plan year by such plan or  
12 issuer in an initial determination (both in the aggre-  
13 gate and categorized by each item and service).

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

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

24 “(5) The average and the median amount of  
25 time (in hours) that elapsed during such plan year

1 between the submission of a prior authorization re-  
2 quest to the plan or issuer and a determination by  
3 the plan or issuer with respect to such request for  
4 each such item and service, excluding any such re-  
5 quests that were not submitted with the medical or  
6 other documentation required to be submitted by the  
7 plan or issuer.

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

21 (2) CLERICAL AMENDMENT.—The table of con-  
22 tents in section 1 of the Employee Retirement In-  
23 come Security Act of 1974 (29 U.S.C. 1001 note) is  
24 amended by inserting after the item relating to sec-  
25 tion 726 the following new item:

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

1 (d) IRC.—

2 (1) IN GENERAL.—Subchapter B of chapter  
3 100 of the Internal Revenue Code of 1986 is amend-  
4 ed by adding at the end the following new section:

5 **“SEC. 9827. PRIOR AUTHORIZATION TRANSPARENCY RE-**  
6 **QUIREMENTS.**

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

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

18 “(2) The percentage and number of prior au-  
19 thorization requests approved during such plan year  
20 by the plan in an initial determination and the per-  
21 centage and number of prior authorization requests  
22 denied during such plan year by such plan in an ini-  
23 tial determination (both in the aggregate and cat-  
24 egorized by each item and service).

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

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

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

19          “(b) MANNER OF PUBLICATION.—Information sub-  
20          mitted and published by a group health plan under sub-  
21          section (a) shall be so published on a group health plan  
22          level and shall in addition, if determined appropriate by  
23          the Secretary, be so submitted and published in the aggre-  
24          gate in such manner as specified by the Secretary (such  
25          as across all group health plans of the sponsor of such

1 plan that are offered within the same insurance market  
2 (as specified in subclause (I), (II), (III), or (IV) of section  
3 9816(a)(3)(E)(iv)).”.

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

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

8 **SEC. 2. PROMOTING COMPARABILITY OF QUALIFIED**  
9 **HEALTH PLANS OFFERED THROUGH AN EX-**  
10 **CHANGE.**

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

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

16 “(i) through which”;

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

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

21 “(ii) that includes, as part of such  
22 comparative information for enrollments  
23 for plan years beginning on or after Janu-  
24 ary 1, 2029, in the case a qualified health  
25 plan offered through such Exchange for

1                   such plan year was offered through such  
2                   Exchange for a previous plan year, the  
3                   most recent information submitted to such  
4                   Exchange with respect to such plan by the  
5                   health insurance issuer of such plan under  
6                   section 2799A-12 of the Public Health  
7                   Service Act;”.