

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

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## 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

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## 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 aggregate and categorized by each item and service).

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

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6  
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 request to the plan or issuer and a determination by  
16 the plan or issuer with respect to such request for  
17 each such item and service, excluding any such requests that were not submitted with the medical or  
18 other documentation required to be submitted by the  
19 plan or issuer.

20  
21  
22 “(6) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests  
23 that were approved, by the plan or issuer during  
24  
25

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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