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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. _____

To direct the Secretary of Labor to require group health plans include certain information on claim denials in annual reports, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. MCBATH introduced the following bill; which was referred to the Committee on _____

A BILL

To direct the Secretary of Labor to require group health plans include certain information on claim denials in annual reports, and for other purposes.

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 ''Health Claim Denial Transparency Act''.

SEC. 2. CLAIM DENIAL TRANSPARENCY REGULATION.

(a) REGULATION.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act and subject to paragraph (2), the Secretary of Labor shall promulgate a regulation requiring all group health plans, as part of the annual report required under section 104(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(a)(1)), to include, with respect to the plan year of the annual report, the following:

(A) The total number of claims for benefits—

(i) submitted during the plan year;

(ii) approved during the plan year;

(iii) denied during the plan year;

(iv) appealed during the plan year; and

(v) of the claims described in clause (iv), the number of claim denials reversed in whole or in part during the appeals process.

(B) The number of pre-service, post-service, and urgent care claims—

(i) submitted during the plan year;

(ii) approved during the plan year;

(iii) denied during the plan year; and

(iv) appealed during the plan year.

(C) The number of in-patient and out-patient claims—

(i) submitted during the plan year;

(ii) approved during the plan year;

(iii) denied during the plan year; and

(iv) appealed during the plan year.

(D) Subject to paragraph (2), the number of claims for prescription drugs—

(i) submitted during the plan year;

(ii) denied during the plan year;

(iii) approved during the plan year; and

(iv) appealed during the plan year.

(E) Subject to paragraph (2), the number of claims for mental health and substance use disorder benefits—

(i) submitted during the plan year;

(ii) denied during the plan year;

(iii) approved during the plan year; and

(iv) appealed during the plan year.

(F) Subject to paragraph (2), the number of claims for medical and surgical benefits relating to the diagnosis or treatment of cancer—

(i) submitted during the plan year;

(ii) denied during the plan year;

(iii) approved during the plan year; and

(iv) appealed during the plan year.

(G) The total dollar amount of—

(i) claims paid during the plan year; and

(ii) claims denied during the plan year.

(H) The total number of claims that were not adjudicated within the time frame required by the claims procedure process of the plan, established pursuant to section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133).

(I) The basis for denials, including the total number of claims denied due to—

(i) medical necessity requirements;

(ii) lack of referral;

(iii) lack of prior authorization;

(iv) services excluded;

(v) administrative reasons; and

(vi) other reasons determined by the Secretary.

(J) The number of claims processed in which artificial intelligence or other automated decision-making tools are utilized, including the number of such claims—

(i) paid during the plan year; and

(ii) denied during the plan year.

(2) EXCEPTION FOR CERTAIN DATA FROM SMALL PLANS.—The Secretary may not require that the annual report include, and a group health plan may not include in such report, the number of claims as described under subparagraph (D), (E), or (F) of paragraph (1) if the plan has received 20 or fewer unique claims described under the applicable paragraph during the plan year.

(b) AMENDING REGULATIONS.—As part of the promulgation described in subsection (a), the Secretary shall amend section 2520.104-46(b)(2) of title 29, Code of Federal Regulations, to require a group health plan with fewer than 100 participants to comply with the reporting requirements of subsection (a).

(c) WAIVER OF MINIMUM REQUIREMENTS.—In the case that the Secretary allows a group health plan to file a simplified report pursuant to section 104(a)(3) of the Employee Retirement Income Security Act (29 U.S.C. 1024(a)(3)), the Secretary shall, at a minimum, require

the group health plan to include all of the information in subsection (a) in such simplified report.

(d) DEFINITIONS.—In this section:

(1) DENIAL.—The term ''denial'' has the meaning given the term ''adverse benefit determination'' in section 2560.503-1(m)(4) of title 29, Code of Federal Regulations.

(2) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given the term in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

(3) POST-SERVICE CLAIM.—The term ''post-service claim'' has the meaning given the term in section 2560.503-1(m) of title 29, Code of Federal Regulations.

(4) PRE-SERVICE CLAIM.—The term ''pre-service claim'' has the meaning given the term in section 2560.503-1(m) of title 29, Code of Federal Regulations.

(5) URGENT CARE CLAIM.—The term ''urgent care claim'' has the meaning given the term ''claim involving urgent care'' in section 2560.503-1(m)(1) of title 29, Code of Federal Regulations.