

119TH CONGRESS
2D SESSION

H. R. 9754

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

JULY 16, 2026

Mrs. MCBATH introduced the following bill; which was referred to the Committee on Education and Workforce

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.

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 “Health Claim Denial
5 Transparency Act”.

6 **SEC. 2. CLAIM DENIAL TRANSPARENCY REGULATION.**

7 (a) REGULATION.—

8 (1) IN GENERAL.—Not later than 1 year after
9 the date of enactment of this Act and subject to
10 paragraph (2), the Secretary of Labor shall promul-

1 gate a regulation requiring all group health plans, as
2 part of the annual report required under section
3 104(a)(1) of the Employee Retirement Income Secu-
4 rity Act of 1974 (29 U.S.C. 1024(a)(1)), to include,
5 with respect to the plan year of the annual report,
6 the following:

7 (A) The total number of claims for bene-
8 fits—

9 (i) submitted during the plan year;

10 (ii) approved during the plan year;

11 (iii) denied during the plan year;

12 (iv) appealed during the plan year;

13 and

14 (v) of the claims described in clause

15 (iv), the number of claim denials reversed
16 in whole or in part during the appeals
17 process.

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

20 (i) submitted during the plan year;

21 (ii) approved during the plan year;

22 (iii) denied during the plan year; and

23 (iv) appealed during the plan year.

24 (C) The number of in-patient and out-pa-
25 tient claims—

- 1 (i) submitted during the plan year;
- 2 (ii) approved during the plan year;
- 3 (iii) denied during the plan year; and
- 4 (iv) appealed during the plan year.

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

- 7 (i) submitted during the plan year;
- 8 (ii) denied during the plan year;
- 9 (iii) approved during the plan year;
- 10 and
- 11 (iv) appealed during the plan year.

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

- 15 (i) submitted during the plan year;
- 16 (ii) denied during the plan year;
- 17 (iii) approved during the plan year;
- 18 and
- 19 (iv) appealed during the plan year.

20 (F) Subject to paragraph (2), the number
21 of claims for medical and surgical benefits re-
22 lating to the diagnosis or treatment of cancer—

- 23 (i) submitted during the plan year;
- 24 (ii) denied during the plan year;

1 (iii) approved during the plan year;

2 and

3 (iv) appealed during the plan year.

4 (G) The total dollar amount of—

5 (i) claims paid during the plan year;

6 and

7 (ii) claims denied during the plan

8 year.

9 (H) The total number of claims that were
10 not adjudicated within the time frame required
11 by the claims procedure process of the plan, es-
12 tablished pursuant to section 503 of the Em-
13 ployee Retirement Income Security Act of 1974
14 (29 U.S.C. 1133).

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

17 (i) medical necessity requirements;

18 (ii) lack of referral;

19 (iii) lack of prior authorization;

20 (iv) services excluded;

21 (v) administrative reasons; and

22 (vi) other reasons determined by the
23 Secretary.

24 (J) The number of claims processed in
25 which artificial intelligence or other automated

1 decision-making tools are utilized, including the
2 number of such claims—

3 (i) paid during the plan year; and

4 (ii) denied during the plan year.

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

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

19 (c) WAIVER OF MINIMUM REQUIREMENTS.—In the
20 case that the Secretary allows a group health plan to file
21 a simplified report pursuant to section 104(a)(3) of the
22 Employee Retirement Income Security Act (29 U.S.C.
23 1024(a)(3)), the Secretary shall, at a minimum, require
24 the group health plan to include all of the information in
25 subsection (a) in such simplified report.

1 (d) DEFINITIONS.—In this section:

2 (1) DENIAL.—The term “denial” has the mean-
3 ing given the term “adverse benefit determination”
4 in section 2560.503–1(m)(4) of title 29, Code of
5 Federal Regulations.

6 (2) GROUP HEALTH PLAN.—The term “group
7 health plan” has the meaning given the term in sec-
8 tion 733(a)(1) of the Employee Retirement Income
9 Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

10 (3) POST-SERVICE CLAIM.—The term “post-
11 service claim” has the meaning given the term in
12 section 2560.503–1(m) of title 29, Code of Federal
13 Regulations.

14 (4) PRE-SERVICE CLAIM.—The term “pre-serv-
15 ice claim” has the meaning given the term in section
16 2560.503–1(m) of title 29, Code of Federal Regula-
17 tions.

18 (5) URGENT CARE CLAIM.—The term “urgent
19 care claim” has the meaning given the term “claim
20 involving urgent care” in section 2560.503–1(m)(1)
21 of title 29, Code of Federal Regulations.

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