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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency"

June 10, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislative proposals that are to be considered before the Energy & Commerce Health Subcommittee on June 10.

We appreciate the Subcommittee's ongoing interest in reviewing health care price transparency policies and efforts to ensure the information available to the public is useful for patients, purchasers and policymakers. We share the frustration that the reporting system that has developed over the last 16 years — one that requires extensive contributions of hospital and health system staff time and resources — does not address underlying transparency concerns or fully provide the information that patients need to understand their out-of-pocket obligations. The hospital field takes transparency compliance seriously, and we want to continue the work of providing patients with essential information on their care. We would caution, however, against codifying regulations that do not meet the goals sought by either patients or health care purchasers and instead result in "transparency in name only." Before Congress considers additional legislative solutions, it will be important to understand how existing

policies are performing, as well as the tremendous financial costs of compliance, to ensure that any future policymaking retains what is working and improves upon what is not delivering true transparency.

The AHA is committed to working with the Subcommittee on additional price transparency concepts, including those vetted by our Price Transparency Task Force, which were shared in an April 27 letter to Energy and Commerce Committee leadership and are summarized here.

We appreciate being part of the ongoing dialogue on health care price transparency and look forward to working with the Subcommittee as they consider additional legislative proposals.

We would like to provide feedback on the following bills.

H.R. _____, [Lower Costs More Transparency Act of 2026]

The bill codifies and expands healthcare price transparency requirements for hospitals, labs, imaging providers, ambulatory surgery centers (ASCs), group health plans/issuers and pharmacy benefit managers (PBMs). Hospitals would be required, beginning Jan. 1, 2028, to publicly post all standard charges, consumer-friendly prices for at least 300 shoppable services, associated national provider identifier (NPI) information and an accuracy attestation. The bill further establishes standard formats, monitoring, audits, corrective action, civil monetary penalties and technical assistance. Similar reporting requirements would be applied to clinical diagnostic labs, imaging services and ASCs, including public price files, consumer-friendly shoppable-service information, enforcement and penalties. Plans would be required to provide cost-sharing information through real-time self-service tools and make public rate/payment data. The bill also includes PBM spread-pricing disclosures and other plan transparency provisions.

AHA Response:

We appreciate that changes made to this version of the Lower Costs, More Transparency Act are seeking to address concerns hospitals had previously expressed to the Energy and Commerce Committee about the version passed by the House in the 118th Congress, including:

- The bill does not prevent the Centers for Medicare & Medicaid Services (CMS) from allowing providers to meet the shoppable services requirement using an online cost estimator tool.

We look forward to working with the committee on any further refinements or changes that need to be made to this bill.

H.R. _____, **[To amend title XXVII of the Public Health Service Act to require hospitals to post prices on the walls.]**

The bill requires each U.S. hospital, beginning Jan. 1, 2028, to post prices physically on the walls in areas specified by HHS. These prices must show the discounted cash price, expressed as a dollar amount, for each CMS-specified shoppable service furnished by the hospital in both inpatient and outpatient settings. If no discounted cash price exists, the hospital must post the median cash price charged to self-pay individuals for the service over the prior three years.

AHA Response:

We have concerns about the practicality of this approach for patients. In general, when someone arrives at a hospital, especially in an emergency (which is how more than half of all patients access a hospital), they are not basing their choice of facility on the price of services. Additionally, patients seeking to use pricing data to inform care decisions for scheduled care would need pricing information prior to arriving at a hospital for treatment. Also, it is unclear whether this requirement would apply to only the 70 services identified by CMS or also to the 300 shoppable services required through current hospital price transparency regulations. We also have concerns this requirement could increase confusion for patients who may have insurance coverage for the service and/or qualify for financial assistance. We caution against underestimating the effort that would be needed to support patients' health coverage literacy to understand the tradeoffs between choosing to use insurance or opting instead to pay cash. This is not a simple choice between which option costs less in the moment; an insured patient choosing to pay cash would forego some of the consumer protections inherent in health care coverage, specifically, the maximum out-of-pocket limits. In other words, a short-term decision to pay less in cash up front could have significant, costly financial consequences later as those costs would not accrue toward their deductible or out-of-pocket maximums. Finally, a static price list does not consider that patients often have a series of costs associated with a course of treatment (e.g. emergency department visit, ambulance costs, physician fees) that would not be included in the posted hospital price. We would recommend that the Subcommittee not advance this bill through the legislative process.

H.R. ____ [To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments.]

The bill requires health insurance issuers, for plan years beginning Jan. 1, 2027, to submit to HHS and publish consumer-friendly information showing how premium revenue is spent. The disclosures would include the percentage of premium revenue spent on claims, quality-improvement activities and other non-claims/overhead categories, plus the percentage retained by the issuer. Medicare Advantage (MA) organizations, beginning in 2027, would be required to publish plan-level revenue, incurred claims, non-claims costs and medical loss ratio (MLR)-related retained amounts. The health insurance exchanges, beginning with 2029 enrollments, would be required to include the most recent issuer overhead/claims-payment information in qualified health plan comparative information.

AHA Response:

We support this bill, as the AHA has become increasingly concerned with how large commercial insurance plans may be gaming MLR regulations by directing qualifying payments to entities within the same corporate umbrella. We also encourage the Subcommittee to consider these changes:

- Rather than only showing the percentage of premium revenue spent on claims, it may be more impactful to show the dollar value of how much of the premium is retained by the insurance company.
- It will be important to standardize definitions across the plans to ensure that they are measuring things such as "quality improvement" in a similar manner.
- While the bill requires the data to be integrated into the information that consumers see when enrolling through the exchanges, that same type of information is not included when enrolling in MA plans.

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.]

The bill requires MA plans and group/individual health plans/issuers that use prior authorization, beginning with 2027 plan years, to submit and publicly post prior authorization transparency data. This data must include lists of all items/services subject to prior authorization, numbers and percentages of requests approved and denied at the initial determination stage, appeal rates, appeal overturn rates by item/service and appeal level and average/median response times. CMS would be required to publish MA plan-level information publicly. Similar requirements would apply to the Public Health Service Act, Employee Retirement Income Security Act, and the Internal Revenue Code for private coverage.

AHA Response:

The AHA supports this legislation. We are pleased that the bill requires reporting at both the plan level as well as categorized at the item/service level, as current plan reports are too broad to prove useful. We would request that additional oversight be considered, such as additional auditing and civil monetary penalties, as well as standardization of the data to allow for meaningful comparisons.

H.R. 5582 Patients Deserve Price Tags

The bill makes significant changes to hospital price transparency requirements by requiring monthly updates to public files of standard charges and consumer-friendly shoppable-service information; after Dec. 31, 2026, hospital consumer-friendly pricing must include all shoppable services, rather than the current regulatory requirement of 300 services. The price transparency requirements would be extended to clinical diagnostic labs, imaging services and hospital-owned/controlled (only) ASCs, with

standardized data elements, consumer-friendly formats, enforcement, technical assistance and penalties. Health plans would be subject to additional cost-sharing and rate-transparency requirements, including self-service tools, machine-readable rate/payment files, plain-language accessibility obligations and PBM spread-pricing-related disclosures. Hospitals would be drawn into contractual disputes between administrative service providers/third party administrators (TPAs)/PBMs and employers by requiring them to provide access to data, methodologies, fees, rebates and alternative-payment information. The bill also requires hospitals to produce explanations of benefits and itemized bills beyond current statutory requirements, with plain-language service descriptions, billing codes, plan responsibility, patient cost sharing, deductible/out-of-pocket status and site of service information.

AHA Response:

The AHA believes this bill deserves significant modifications, as it goes well beyond current hospital price transparency regulatory requirements and would place additional administrative burdens on hospitals without commensurate benefit for patients, purchasers or policymakers. We encourage the Subcommittee to avoid creating duplicative, inconsistent or operationally impossible requirements that undermine existing transparency efforts.

Some of the most concerning provisions include:

- The bill does not consider the current regulatory environment. CMS already requires regular, significant updates to hospital price transparency rules, including those that took effect as recently as calendar year 2026. Legislating new, conflicting requirements now would disrupt CMS' progress and create confusion for patients and hospitals.
- The bill eliminates the option of using price estimator tools to meet the shoppable services requirement. These tools are currently the most consumer-friendly way for patients to understand their out-of-pocket costs. Replacing them with static spreadsheets would be harder for patients to navigate, removes personalized cost sharing information and does not reflect plan specific benefit designs. We believe this change would reduce, not improve, price transparency for patients.
- The bill requires machine-readable files to be updated monthly, rather than the current requirement of once a year. Hospitals currently require 3–4 months to produce compliant machine-readable files and these more frequent updates would be operationally challenging and costly, especially for small and rural hospitals. This approach adds regulatory burden without improving patient-level transparency.
- Enforcement efforts in the bill are disproportionately targeted at hospitals, rather than other health care stakeholders. For example, the bill dramatically increases penalties and mandates CMPs for every violation, removing CMS discretion. While all hospitals would face annual audits, only up to 20 insurers would be subject to review. Also, the health plans are provided twice as much time to

correct issues (90 days vs. 45 for hospitals). It is important to also note that hospitals have already undergone thousands of CMS reviews with very few fines.

- The bill applies ASC transparency rules only to hospital-owned ASCs, leaving out other types of ASCs. Patients would not receive complete information on pricing across all ASCs.
- The bill makes substantial changes to current contract terms between providers and TPAs. The bill requires disclosure of proprietary, negotiated terms, including algorithms and payment formulas. Any plan fiduciary (even investment committees) would be able to demand clinical records from hospitals and health systems. The bill also removes limits on the volume of data requested by the health plans. Ultimately, the bill expands the Employee Retirement Income Security Act jurisdiction to providers, which would void existing contracts and impose new penalties on hospitals and health systems.
- The bill links patient billing to advanced explanation of benefits (AEOBs), when the AEOB standards are still being developed as part of the No Suprises Act (NSA). Currently, providers may not even receive AEOBs, so linking final patient bills to these still unsettled documents is premature and does not consider existing statute.
- The bill establishes unrealistic itemized billing requirements. For example, a 30-day billing deadline is impossible for hospitals to meet when insurers have not yet adjudicated claims during that time period. It is unclear which "estimate" hospitals must use (good faith estimate, AEOB or a new one). Also of concern, the bill prohibits collections by hospitals if final charges exceed the estimate — with no allowance for clinical changes and no dispute resolution pathway. These statutory changes are far more restrictive than the NSA and would create significant financial and operational harm for hospitals and health systems.

H.R. [To amend title XVIII of the Social Security Act to require the inclusion of certain information in Medicare Advantage Encounter Data]

The bill requires MA encounter data for items/services furnished in plan years beginning Jan. 1, 2027, to include additional payment and assessment information. This data must include the allowed amount for the item/service and beneficiary cost sharing, including deductibles, copayments and coinsurance. The bill also requires indicators showing whether, before the item or service is delivered, the enrollee received an at-home health risk assessment from a specified assessment entity or another assessment entity.

AHA Response:

The AHA supports this legislation.

H.R. [To amend title XI of the Social Security Act to require mandatory reporting with respect to certain health-related ownership information.]

The bill creates mandatory HHS ownership reporting for specified health care entities, including hospitals, physician-owned practices with more than 25 physicians, practices

owned by specified business structures, ASCs and independent freestanding emergency departments, with initial reports due Jan. 1, 2027, and annual updates thereafter. The reports must include business structure, tax status, mergers/acquisitions/ownership changes, parent-company and beneficial-owner information and for hospital entities, debt, real-estate and certain capital-gains information. HHS would be required to publish annual public reports beginning Jan. 1, 2029, with ownership, tax-status and consolidation-trend information disaggregated by business structure or provider type. There would be annual random audits and CMPs up to $5 million per report for hospitals over 30 beds and up to $2 million for other specified entities.

AHA Response:

The AHA has serious concerns about this legislation. It is overly burdensome — for example, it would require certain hospitals to report every time a physician chooses to take a job elsewhere. It also is duplicative to other reporting requirements. CMS already imposes reporting on private equity transactions and the Federal Trade Commission and the Department of Justice require information regarding large mergers and acquisitions before they occur through antitrust Hart, Scott, Rodino Act reporting. We recommend identifying and accounting for the data collected through existing reporting avenues before imposing additional requirements.

H.R. ____ [To amend title XVIII of the Social Security Act to limit the compensation that may be paid to agents and brokers by Medicare Advantage (MA) organizations.]

The bill requires HHS, beginning not later than Jan. 1, 2028, to set a maximum compensation amount for agents, brokers or other third parties enrolling individuals in MA plans. Compensation is defined as commissions, bonuses, gifts, prizes, training/testing/appointment costs, transportation and appointment reimbursements, enrollment-related reimbursements and other remuneration specified by HHS. MA organizations would be prohibited from entering or renewing contracts that directly or indirectly inhibit agents/brokers from objectively recommending the MA plan that best fits an individual's health care needs. MA organizations would be required, starting with 2028 plan years, to report whether each enrollee was enrolled by an agent/broker/third party and the type and amount of related compensation; CMS must include individual-level enrollment-source data in the Chronic Condition Warehouse maintained by CMS and publicly report aggregate compensation data by organization.

AHA Response:

The AHA supports this legislation.