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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

of the

U.S. House of Representatives

"Full Committee Markup"

July 21, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislation being marked up by the Energy and Committee on July 21.

HR 9393, **Lower Costs, More Transparency Act of 2026**

The Amendment in the Nature of a Substitute (AINS) to HR 9393 codifies healthcare price transparency requirements for hospitals, labs, imaging providers, ambulatory surgery centers (ASCs), group health plans/issuers and pharmacy benefit managers (PBMs). Hospitals are required to post all gross charges, payer-specific negotiated charges and discounted cash prices in a machine-readable file (MRF), as well as in a consumer-friendly format for at least 300 shoppable services, with updates at least annually. Hospitals must also submit attestations confirming the accuracy of the information. The Secretary of the Department of Health and Human Services (HHS) is tasked with establishing uniform methods and formats for these disclosures by Jan. 1, 2028. Compliance will be monitored through audits and complaint evaluations, with civil

monetary penalties imposed for non-compliance, scaled by hospital size and severity of violations. Waivers or penalty reductions may be granted under specific hardship or rural access conditions. Ownership and business structure information of entities with significant interests in hospitals must also be disclosed annually. Similar price transparency reporting requirements would be applied to clinical diagnostic labs, imaging services and ASCs, including public price files and specifications for enforcement and penalties. Group health plans and health insurance issuers must provide participants with timely cost-sharing information upon request via self-service tools or alternative disclosures. This includes in-network rates, maximum allowed amounts for out-of-network providers, estimated cost-sharing, accumulated deductibles, frequency limitations, prior authorization requirements and any financial incentives.

The AINS also establishes requirements for health plan service providers, including third-party administrators and pharmacy benefit managers, to disclose detailed information such as contractual methodologies, rebates, fees and alternative payment arrangements to group health plans and issuers every six months. It also increases insurance accountability by requiring health plans, issuers and Medicare Advantage (MA) organizations to disclose prior authorization data, administrative overhead, claims spending, standardized plan information, encounter data and supplemental benefit utilization.

TITLE I – HEALTH CARE PRICE TRANSPARENCY

Section 101: Hospital Price Transparency

AHA Response:

We appreciate the committee's interest in improving healthcare price transparency policies, and we support efforts to ensure the information available to the public is useful for patients, purchasers and policymakers. While the hospital data is similar to what is currently required by the regulation, we would note that by inserting specific posting requirements into statute, Congress is effectively limiting flexibility for the Centers for Medicare & Medicaid Services (CMS) to continually improve the requirements to better reflect a changing transparency environment and/or what is most valued by stakeholders. By codifying and thus making the data requirements more prescriptive, certain innovations will be difficult to achieve absent additional legislative action.

It seems that the AINS acknowledges that the current formats for meeting the hospital price transparency requirements for shoppable services are beneficial to the key stakeholders, referencing existing formats in use as of the date of enactment, and in consultation with the HHS secretary. One of the current permissible formats is a price estimator tool, which is the most consumer-friendly way for patients to understand their out-of-pocket costs. These tools are an important component of healthcare price transparency efforts, and we encourage the committee to clarify that hospitals can continue to use them to meet the shoppable service requirements.

Title II – Insurance Accountability

AHA Response:

The AHA appreciates the committee's efforts to include policies that promote and increase transparency among commercial insurers. As previously noted, we support these provisions, including:

Section 201: Displaying Prior Authorization Rates. This section would require group and individual health plans and issuers that use prior authorization to submit and publicly post prior authorization transparency data. This data must include lists of all items and 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 and service and appeal level, and average/median response times.

Section 202: Ensuring Health Insurer Accountability Through Publishing of Overhead Costs and Claim Payments. This section would require health insurance issuers to submit to HHS and publish consumer-friendly information showing how premium revenue is spent, including the percentage of premium revenue spent on claims, quality-improvement activities and other non-claims and overhead categories, plus the percentages retained by the issuer. MA organizations would be required to publish plan-level revenue, incurred claims, non-claims costs and medical loss ratio-related retained amounts.

Section 203: Promoting Comparability of Qualified Health Plans Offered Through an Exchange. This section would require health insurance marketplace websites to post recent data on prior authorization rates and plan overhead and claims costs.

Section 204: Guidance on Provision of Certain Insurance Information in Standardized Plain Language Format. This section would require HHS to update guidance in plain language regarding the disclosure of benefit and coverage information by group health plans, health insurance issuers offering group or individual health insurance coverage, and MA plans.

Section 205: Establishing Requirements With Response to the Use of Prior Authorization Under Medicare Advantage Plans. This section would streamline prior authorization requirements under MA plans by establishing an electronic prior authorization standard to streamline approvals, reduce the time a health plan is allowed to consider a prior authorization request, require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials, and encourage MA plans to adopt policies that adhere to evidence-based guidelines.

Section 206: Requiring the Inclusion of Certain Information in Encounter Data. This section would require MA encounter data for items and 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 or service and beneficiary cost sharing, including deductibles, copayments and coinsurance.

H.R. 9390, Prices on the Wall Act of 2026

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:

While we support providing patients with clear, meaningful pricing information to help them make informed decisions about their care, we remain concerned that requiring hospitals to post discounted cash prices may not provide patients with the information they need when it would be most useful. More than half of all patients arrive at a hospital through the emergency department, where the urgency of their medical needs may limit their ability to compare facilities based on price. For scheduled services, patients generally need pricing information before arriving at the hospital to incorporate it into their care decisions meaningfully.

We also are concerned that displaying discounted cash prices without sufficient context could make it harder for some patients to determine which payment option best serves their individual circumstances, particularly if they have insurance coverage or may qualify for financial assistance. Patients should have access to clear information about the full implications of choosing to use insurance or pay cash. The decision involves more than comparing the immediate price: an insured patient who pays cash may forgo important consumer protections associated with coverage, including having those payments count toward a deductible or annual out-of-pocket maximum. As a result, paying less up front could lead to higher overall costs later in the year.

Finally, a static price list may not reflect the full range of services and charges associated with a course of treatment, such as ambulance transportation, physician services, or other care provided outside the hospital's posted price. Without that broader context, the information may not give patients a complete picture of their potential financial responsibility.