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Statement for the Record

House Energy and Commerce Committee, Subcommittee on Health Markup of Bills to Safeguard Americans from Illicit Substances and Increase Price Transparency in Our Health Care System June 25, 2026

The Federation of American Hospitals (FAH) appreciates the opportunity to submit this Statement for the Record as the Subcommittee examines health care price transparency. As the federal representative for 1,000 taxpaying hospitals across the country, our member hospitals employ nearly 500,000 health care workers and care for millions of patients each year.

This Committee is taking important steps toward ensuring that patients have usable information about their health costs. Health care affordability solutions must reflect thoughtful policies that are oriented toward the patient's needs. Federation members recognize and appreciate the commitment to implementing patient-focused and meaningful policies. Our members have made significant investments in consumer-friendly tools for patients to estimate their expected out-of-pocket costs before receiving care, helping patients better understand their cost-sharing responsibilities and make informed health care decisions. Additionally, our members are working with the federal government on transparency efforts, providing data and insights on the input costs that impact patient affordability.

Patients need clear, actionable information about their expected out-of-pocket costs, which can only be achieved through coordinated efforts among hospitals, health plans, employers and policymakers to improve access to timely and accurate cost information.

Federation members share the larger goal of transparent pricing policies reflected in the provider-oriented bills before the Committee today and our comments below will reflect some practical and operational considerations that we believe should be reflected in the legislation.

Below is feedback from the Federation on the legislation being considered:

H.R. ____, Lower Costs, More Transparency Act of 2026

Over the last few years, transparency requirements have undergone significant changes. The Federation has recommended maintaining stability in transparency reporting requirements to benefit hospitals and groups that utilize hospital transparency data. Federation members remain committed to price transparency and believe that patients need reliable information about their healthcare costs in a way that reflects their true out-of-pocket expenses, and with transparency that provides meaningful information to patients about the services they are receiving.

The bill's requirements of posting standard charges and prices for each item and service furnished by the hospital, gross charges, discounted case price, payor-specific negotiated charges, and de-identified maximum and minimum negotiated charges are all aligned with current CMS reporting requirements.

The Federation looks forward to continuing to contribute and provide feedback.

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

Current regulations require hospitals to publicly post standard charges (including gross charges), cash prices, payer-specific negotiated rates, and minimum negotiated charges. These changes help increase transparency and provide valuable information to patients looking at shoppable services. Hospitals must have public standard charges for as many of the CMS-specified shoppable services that they provide, as well as all other hospital-selected shoppable

services for a combined total of at least 300 shoppable services. The overall goal of price transparency and consumer choice that this bill is aiming to address can be accessed by shoppable services files or price estimator tools, which can generate a personalized cost estimate that considers a patient's insurance information.

Most hospitals, including FAH members, have these files available on their websites. These tools also must include plain language descriptions of services, group them with ancillary services, and provide discounted cash prices, payer-specific negotiated charges, and minimum and maximum negotiated charges. This current framework allows consumers to access a wide variety of information about shoppable services in addition to just prices. Moving to require a physical posting of prices would not only be duplicative of existing tools geared towards consumers but would also represent a step backwards in terms of patient accessibility.

MA and Insurance Transparency Bills

Transparency of plan practices is a necessary tool to provide a better understanding of patient access. This is especially prevalent as the HHS OIG has published multiple reports citing risks that MA plan authorization denials have jeopardized access to care.¹ The Prior Authorization Accountability Act proposes requiring health plans to publicly report detailed prior authorization data across all four major coverage frameworks: Medicare Advantage, private/ACA Marketplace coverage, employer plans under ERISA, and tax-code group plans. Having access to this data would provide insight into delays in care and administrative burdens. The Federation recommends pairing this policy with standardized CMS prior authorization definitions and processes so plans report against set in common terms and extending the framework beyond prior authorization to also include post-service payment outcomes.

Yet transparency into prior authorization practices alone is insufficient to capture the full picture of how health plans affect patient access and premium value. Understanding whether premium dollars are reaching patients requires equal visibility into how insurers allocate their overall spending: making the overhead cost and claim payment disclosure bill a necessary complement to prior authorization reporting. The Federation supports the bill's amendment to title XXVII of the Public Health Service Act and title XVIII of the Social Security Act requiring commercial insurers and Medicare Advantage organizations to publicly disclose how premium dollars are allocated among clinical claims, overhead, and insurer-retained earnings. This is an important step forward in plan transparency. Further, FAH urges the Committee to address how consolidation and vertical integration can affect the MLR framework and ensure that administrative functions are not mischaracterized as medical spending.

Alarming practices of MA and other insurance plans, such as improper prior authorization denials, improper denials for lack of documentation, and improper payment request denials, can leave hospitals having to divert precious resources to responding to these tactics. By withholding coverage, these plans are harming patients and limiting access and affordability of medically necessary care. The Federation supports the Improving Seniors' Timely Access to Care Act of 2025, which addresses shortcomings in MA plan oversight and provides more transparency into insurer behavior.

The Federation also supports efforts to ensure that beneficiaries, policymakers, and regulators have access to meaningful information that can be used to improve program oversight and decision-making, including MA encounter data. In a 2024 report,² the HHS Office of Inspector General found that MA organizations received an estimated \$7.5 billion in risk-adjusted payments based on diagnoses reported only through health risk assessments and chart reviews that did not appear on other service records. The report identified approximately 1.7 million beneficiaries whose diagnoses were documented solely through these mechanisms, raising concerns about whether those conditions were subsequently treated or managed through the delivery of care. This also raises questions about whether MA plans are effectively managing beneficiaries with chronic conditions and ensuring that patients are receiving medically necessary


¹ Department of Health and Human Services Office of Inspector General. "The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates." June 2026.

<https://oig.hhs.gov/documents/audit/11693/OEI-09-24-00330.pdf>

Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>

² Department of Health and Human Services Office of Inspector General. "Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive Up Payments to Plans by Billions." October 2024.

<https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf>



care. The Federation supports requiring MA plans to include additional information in the encounter data they submit to CMS, but would suggest clarifying what “complete” encounter data would entail moving forward.

The Federation of American Hospitals appreciates the opportunity to provide comments on the bills before the Subcommittee. Our members share the goal of making health care more patient-focused and accessible, with cost transparency as an integral component of that effort. The work of this Subcommittee has drawn important attention to the issue of patient affordability and we look forward to working with you as consider this legislation.