Federation of American Hospitals

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Statement for the Record

House Energy and Commerce Committee, Subcommittee on Health
"Legislative Hearing to Examine Policies Increasing Price Transparency for Patients and Employers"
June 10, 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 has dedicated significant time and work into health care affordability, and Federation members recognize and appreciate the commitment to implementing patient-focused and meaningful policies. Taxpaying hospitals have invested in consumer-friendly tools that allow patients to estimate their expected out-of-pocket costs before receiving care. Our members have made significant investments in consumer-friendly tools to help 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.

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

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

Federation members remain committed to price transparency and believe that patients need reliable information about their health care costs in a holistic way that reflects their true out-of-pocket expenses and with transparency that provides meaningful information about the services they are receiving.

In just a few years, transparency requirements have changed significantly, and both hospitals and the users of hospital transparency data would benefit from a consistent and broadly adopted reporting structure. That is why the Federation has recommended maintaining a period of stability in transparency reporting requirements to allow for further strengthening of already widespread hospital compliance with current CMS regulations.

This discussion draft would require posting of standard charges and prices for each item and service furnished by the hospital, the gross charge, the discounted case price; payor-specific negotiated charges; and de-identified maximum and minimum negotiated charges. Hospitals would also be required to make public information about CMS-specified shoppable services in a consumer-friendly format. These requirements are aligned with current CMS reporting requirements.

The Federation looks forward to contributing and providing feedback as the Committee proceeds with its deliberations.

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

Federation members have invested heavily to comply with existing regulations, which require hospitals to publicly post standard charges, including gross charges, cash prices, payer-specific negotiated rates and the minimum negotiated

charges, in a format easy for patients to understand when looking at shoppable services. The addition of a physical posting requirement would be duplicative of existing consumer-friendly options already available.

Currently, under 4*5 CFR § 180.60*, a hospital must make public standard charges for as many of the 70 CMS-specified shoppable services that it provides, and as many additional hospital-selected shoppable services as necessary for a combined total of at least 300 shoppable services. In selecting services, a hospital must consider the rate at which it provides and bills for that shoppable service.

This requirement can be satisfied through the release of a shoppable services file or by offering a price estimator tool that generates a personalized out-of-pocket estimate that factors in the individual's insurance information. Most hospitals, including FAH members, post these files to their websites.

The display must contain plain language descriptions of the services, group them with ancillary services and provide discounted cash prices, payer-specific negotiated charges and de-identified minimum and maximum negotiated charges.

The Federation views a new physical posting requirement as less accessible to patients than the current framework.

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.]

Meaningful information that beneficiaries, policymakers and regulators can understand and act upon is a tool to enhance appropriate plan conduct, preserve access to care, protect beneficiary benefits and safeguard the long-term integrity of the Medicare program and Trust Fund.

This discussion draft would require commercial health insurers and Medicare Advantage organizations to publicly disclose, beginning with plan year 2027, how their premium dollars are spent, including the share going to clinical claims, the share consumed by overhead and other non-claims costs, and the share the insurer retains, with the commercial data later utilized in Exchange plan-comparison tools starting in 2029.

This is a step toward more plan transparency. The draft builds on the existing medical loss ratio (MLR) framework, which is not fully transparent as currently structured.

Changes in the structure of the insurance market warrant renewed attention to how MLR standards are implemented. Consolidation and vertical integration have created new ways for insurers to technically comply with MLR requirements while shifting premium revenue within affiliated corporate structures. Payments to insurer-owned provider entities, pharmacy benefit managers or other subsidiaries may be counted as medical spending under current rules even when those funds remain within the same corporate family. The Medicare Payment Advisory Commission has observed that traditional measures of health plan financial performance may not fully capture insurer profitability when plans are part of larger integrated organizations that include providers and other health care businesses.[1]

To improve transparency and reinforce the accountability objectives of the MLR framework, targeted policy changes could allow regulators to evaluate the extent of vertically integrated spending and ensure that administrative functions performed by affiliated entities are not mischaracterized as medical spending. That would allow for public reporting of MLR data to distinguish direct medical claims payments from other forms of reported medical spending, including quality improvement activities and payments to affiliated entities. The Federation has provided recommendations for the kind of information that would give patients, providers and policymakers a more clear picture of how premium dollars are used.[2]

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.]

[1] Marketplace 2026 Open Enrollment Period Report: National Snapshot | CMS
[2] NBPP-Proposed-Rule-FAH-Comments-3.13.26.pdf

The HHS OIG has published multiple reports[3] citing risks that Medicare Advantage plan authorization denials jeopardized access to care. Transparency of plan practices will contribute to a better understanding of patient access.

This discussion draft would require health plans to publicly report detailed prior authorization data – items and services subject to prior auth, initial approval and denial rates, appeal frequency and overturn rates (including at judicial review) and average and median decision times – across all four major coverage frameworks (Medicare Advantage, private/ACA-market coverage under the PHSA, employer plans under ERISA, and tax-code group plans under the IRC), reported at the plan level beginning with plan years on or after January 1, 2027. A separate provision requires this data to appear on ACA Exchange plan-comparison websites starting in 2029.

The policy would bring greater transparency to better understand care delays and administrative burden. Appeal-overturn data in particular helps demonstrate where initial denials are unjustified. To make the reporting comparable and auditable, it should be paired with standardized CMS prior authorization definitions and processes so plans report against set common terms rather than variable self-defined ones, along with reporting at the category of service level and not only in the aggregate (e.g., inpatient or outpatient hospital services, inpatient rehabilitation facility services, inpatient psychiatric services) to be transparent about payer denials of prior authorization requests for high-intensity and time-critical items and services at disproportionately high rates.

This draft is a constructive step toward greater payer accountability, bringing needed transparency to prior authorization, a persistent source of care delays for patients and administrative burden for hospitals. Its scope, however, is limited to the pre-service authorization stage. It does not reach the other mechanisms by which plans reduce or deny payment for care that was actually delivered, including post-service claim denials, down-coding and recoupments. As a result, a plan could approve a prior authorization request, count it as an approval under this bill and still deny payment on the resulting claim. To give patients, providers and policymakers a complete picture of payer denial practices, the framework should extend beyond prior authorization to these post-service payment outcomes.

H.R. 5582, Patients Deserve Price Tags (Reps. James and Goodlander)

The Federation is eager to provide feedback on the legislation and looks forward to working with the sponsors and Committee. Multiple regulatory and legislative actions have been taken to promote hospital price transparency to support the interests of the consumer, and our members have invested heavily in innovative resources to provide patients with information on their cost sharing responsibilities. As drafted, there are deep concerns about the bill's impact on taxpaying hospitals and other providers, as well as the utility of the information to patients.

The Federation supports a stable and consistent transparency policy that makes it easy for consumers to access usable information and ensures that price transparency is available to regulators and the public.

H.R. 9117, Clear Healthcare Expense Cost Knowledge Act of 2026 (Rep. Langworthy)

The Federation looks forward to engaging with the Committee on the *Clear Health Expense Cost Knowledge (CHECK) Act* as work on the bill continues. While the information required in the bill could be helpful to patients, the imposition of a new itemized-billing and collections-limitation regime on hospitals and other providers (Section 4) is concerning. Much of what it requires already exists under federal law and applies to hospitals of every type.

All hospitals already furnish good-faith estimates under the No Surprises Act, and all hospitals already maintain machine-readable files and consumer-friendly pricing displays under the federal hospital price transparency rule (45 CFR Part 180). Standardized billing codes and electronic claim formats are likewise the long-established norm under HIPAA. These frameworks apply across the board, but the Federation is concerned that new requirements add another compliance obligation, enforcement trigger and another set of requirements that may not align with those under current law.

H.R. ____, [To amend title XVIII of the Social Security Act to require the inclusion of certain information in Medicare Advantage encounter data.]

[3] Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending | U.S. GAO

The Federation supports efforts to ensure that beneficiaries, policymakers and regulators have access to meaningful information that can be used to improve program oversight and inform decision-making.

In a 2024 report, the HHS Office of Inspector General found that Medicare Advantage 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. (HHS Office of Inspector General, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive Up Payments to Plans by Billions* (OEI-03-23-00380, Oct. 24, 2024)).

OIG concluded that the absence of follow-up care raises concerns that either the diagnoses were inaccurate or beneficiaries did not receive needed care for serious conditions reported through health risk assessments. These findings raise important questions about whether Medicare Advantage plans are effectively managing beneficiaries with chronic conditions and ensuring patients receive the medically necessary care and services needed to treat and monitor those conditions. (HHS Office of Inspector General, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive Up Payments to Plans by Billions* (OEI-03-23-00380, Oct. 24, 2024)).

This discussion draft amends Section 1859 of the Social Security Act to require Medicare Advantage plans to include additional information in the encounter data they submit to CMS. For each item or service, plans would have to report the allowed amount and the enrollee's cost sharing (deductibles, copayments and coinsurance) and would have to flag whether the enrollee received an at-home health risk assessment earlier in the plan year, distinguishing between assessments performed by a "specified assessment entity" and those performed by other assessment entities.

The Federation supports the bill's objectives and further suggests clarifying what "complete" encounter data must include.

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

Taxpaying hospitals are a critical part of the nation's health care system, delivering care while contributing billions of dollars in federal, state and local taxes that support public priorities. All hospitals require access to capital to invest in facilities, technology, workforce and services that meet the needs of the communities they serve, whether that capital comes from government sources, philanthropic support or private markets. Hospitals should be judged by the care they provide and the outcomes they achieve, not by their ownership structure. The extensive ownership and financing disclosures required by this legislation do not provide meaningful insight into quality, patient outcomes or community impact. Instead, the bill would impose significant new reporting and compliance requirements on providers without a clear connection to improving patient care or informing patient choice. In fact, a large portion of the ownership and organizational information required by the bill is already reported through the CMS-855A Medicare enrollment process and, for publicly traded companies, through Securities and Exchange Commission (SEC) filings. The requirements in the legislation overlap, in whole or in part, with existing public reporting for publicly traded hospital companies that already file with the SEC. As a result, the legislation would create substantial duplicative reporting obligations while providing little new information that would help patients, policymakers or regulators assess the quality, value or accessibility of care.

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