Federation of American Hospitals

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Statement for the Record

House Energy and Commerce Committee, Full Committee Markup

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The Federation of American Hospitals (FAH) appreciates the opportunity to submit this Statement for the Record as the Committee considers health care transparency legislation. As the federal representative for over 1,000 taxpaying hospitals across the country, our member hospitals employ nearly 500,000 health care workers and care for millions of patients every year, and we appreciate the Committee's commitment to implementing patient-focused and meaningful policies that address health care access and affordability. Our members have made significant investments in consumer-friendly tools to help patients better understand their cost-sharing responsibilities and collaborated with the federal government on transparency efforts.

In order to make informed decisions about their health care, patients need clear, actionable information about their expected out-of-pocket costs. This can only be achieved through coordinated efforts among hospitals, health plans, employers and policymakers to improve access to timely and accurate cost information.

FAH members share the larger goal of increasing transparency reflected in the bills before the Committee today and our comments below reflect some practical and operational considerations that we believe should be reflected in the legislation.

H.R. 9393, Lower Costs, More Transparency Act of 2026

FAH continues to emphasize the importance of maintaining stability in transparency reporting requirements to help support hospitals and groups that utilize hospital transparency data. Patients need reliable information about the health care services they are receiving, including their true out-of-pocket costs. 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. FAH and its members are committed to transparency and look forward to continuing to engage with the Committee on this legislation.

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

Current regulations require hospitals to publicly post standard charges (including gross charges), cash prices, payer-specific negotiated rates and minimum negotiated charges.1 The CMS requirements provide valuable information to patients reviewing shoppable services. Today, hospitals must have public standard charges for as many of the CMS-specified shoppable services that they provide and other hospital-selected shoppable services for a combined total of at least 300 shoppable services. The overall goal of 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. The current framework gives consumers access to a wide array of information about shoppable services in addition to price, including plain-language descriptions, payer-specific negotiated charges and minimum and maximum negotiated charges. Requiring

hospitals to physically post these prices would be duplicative of these existing resources, which could create confusion and decrease patient accessibility.

In addition to practical concerns about the location of price information, there is also a need to examine the information requirements included in the legislation as drafted. For example, information from a three-year lookback period may be less accurate for a patient than information from the past year. It may be historically accurate but not helpful for a patient assessing current pricing information.

FAH continues to align with the Committee's goals of transparent pricing and easy and convenient patient access to pricing information. As written, this legislation could lead to information being posted which does not reflect a patient's actual out-of-pocket costs. FAH encourages the Committee to revisit what kind of information is provided and where the information is housed.

H.R. 9397, Premium Transparency Act

The Premium Transparency Act would require commercial health insurers and Medicare Advantage (MA) organizations to publicly disclose, beginning in 2027, how their premium dollars are spent. This includes the share going to clinical claims, overhead and non-claims cost and the share the insurer retains. Allowing beneficiaries, policymakers and regulators access to this meaningful information enhances appropriate plan conduct and helps safeguard the long-term integrity of Medicare and the Medicare Trust Fund. While this is an important step forward in plan transparency, FAH supports the intent of this legislation and urges the Committee to expand MA transparency requirements to ensure MLR reporting captures spending across vertically integrated entities and prevents administrative functions from being mischaracterized as medical spending.

H.R. 9396, Prior Authorization Accountability Act

Transparency of plan practices is necessary to gain a better understanding of the barriers affecting patients, particularly in Medicare Advantage. The HHS OIG has published multiple reports citing risks that MA prior authorization denials have jeopardized access to medically necessary care.2 The Prior Authorization Accountability Act would require health plans to publicly report detailed prior authorization data--items and services subject to prior authorization, initial approval and denial rates, appeal frequency and overturn rates (including at judicial review), average and median decision times—across MA, private/ACA marketplace, ERISA plans, and tax-code group plans. An additional provision requires this data to be posted on the ACA Exchange plan comparison website by 2029.

While this bill is an important step towards greater payer accountability, its scope is limited to pre-service authorization. Other mechanisms of reducing or denying payment for care that was already delivered must be addressed simultaneously. As drafted, plans could approve a prior authorization request, count it as an approval under this bill and then deny payment on the claim later. FAH recommends that the framework extend to account for post-service outcomes in order to give the public a complete picture of payer denial practices. In addition, we recommend the bill specify that the Secretary establish reporting deadlines ensuring the posted information remains current and decision-relevant, rather than allowing it to lag years behind actual plan practices.

H.R. 3514, Improving Seniors' Timely Access to Care Act of 2025

The alarming practices of MA and other insurers limiting affordability and restricting access to medically necessary care are deeply concerning to FAH. These tactics not only harm patients but also place additional burdens on hospitals and caregivers. The Improving Seniors' Timely Access to Care Act streamlines the prior authorization process—reducing the administrative burden on providers and patients. Reducing this additional strain on providers allows them to care for their patients more effectively and efficiently while avoiding unnecessary delays in care. FAH urges passage of this important legislation.

H.R. 9392, Medicare Advantage Cost Transparency Act

Beneficiaries, policymakers and regulators deserve access to meaningful information that can be used to improve program oversight and help inform decision-making. The Medicare Advantage Cost Transparency Act requires MA plans to include additional information in the encounter data they submit to CMS: for each service, plans must report the allotted 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 in the plan year, and whether the assessment was done by a "specified assessment entity."

While FAH supports the bill's objectives, further clarification is needed on what "complete" encounter data must include. While requiring MA plans to report allowed amounts and cost-sharing is a valuable step toward transparency, the allowed amount alone does not show what plans actually pay providers for the care furnished to beneficiaries. The CMS-specified electronic file format that plans send after a claim is submitted (also known as 835 remittance advice), by contrast, captures not only the actual amount paid but also claim denials and delays in payment—critical indicators of whether plans are meeting their obligation to reimburse for covered care. We therefore urge that the bill be strengthened to also require reporting of the information conveyed on the 835, so that CMS and policymakers have full transparency into what Medicare Advantage plans truly spend on beneficiary care and can confirm that providers are being adequately and timely reimbursed.

In conclusion, as work on these important issues progresses, FAH members appreciate the opportunity to provide comments on the legislation before the Committee. Transparency should reflect the out-of-pocket costs that a patient will incur, including the impact of insurance. FAH encourages the Committee to address the increasing burden of rising premiums and high deductibles that patients face. We look forward to continuing a dialogue on how best to ensure that patients can easily access accurate information about their health costs, and that all stakeholders in the health ecosystem share the responsibility for transparency.