

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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June 8, 2026

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee Majority Staff
Re: Subcommittee on Health Hearing on June 10, 2026

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, June 10, 2026, at 10:15 a.m. (EST) in 2123 Rayburn House Office Building. The hearing is entitled, “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency.”

The Subcommittee intends to discuss the following pieces of legislation:

- H.R. ____, [Lower Costs, More Transparency Act of 2026]
- H.R. ____, [To amend title XXVII of the Public Health Service Act to require hospitals to post prices on the walls.]
- 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.]
- 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.]
- H.R. 5582, Patients Deserve Price Tags Act (Reps. James and Goodlander)
- H.R. 9117, Clear Healthcare Expense Cost Knowledge Act of 2026 (Rep. Langworthy)
- H.R. ____, [To amend title XVIII of the Social Security Act to require the inclusion of certain information in Medicare Advantage encounter data.]
- H.R. ____, [To amend title XI of the Social Security Act to require mandatory reporting with respect to certain health-related ownership information.]
- 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 organizations.]

II. WITNESSES

- **Carol Skenes**, Chief of Staff, Turquoise Health
- **Shawn Gremminger**, President and Chief Executive Officer, National Alliance of Healthcare Purchaser Coalitions
- **Benedic Ippolito, Ph.D.**, Senior Fellow, American Enterprise Institute
- **Christopher Whaley, Ph.D.**, Associate Director of the Center for Advancing Health Policy through Research and Associate Professor of Health Services, Policy and Practice, Brown University School of Public Health
- **Sophia Tripoli, MPH**, Senior Director of Health Policy, Families USA

III. BACKGROUND

This legislative hearing builds on the Committee’s health affordability series and will explore several policies to increase transparency in the health care sector. Specifically, this hearing will examine legislation to enhance transparency for health plans’ rate and payment information, services furnished in hospitals and ambulatory surgical centers (ASC), and clinical laboratory tests and imaging services. The hearing will also consider discussion drafts to require hospitals to post on their walls the discounted case price of shoppable services specified by the Centers for Medicare & Medicaid Services (CMS) and to enhance consumers’ understanding of plans’ overhead costs and use of prior authorization when shopping for plans.

During the March 18 hearing on the provider landscape, several Members of the Committee, as well as witnesses testifying before the Subcommittee, highlighted how meaningful price transparency has the potential to help consumers and employers make more informed decisions about the cost and quality of care.¹ The Committee has worked over several years on a bipartisan basis to improve transparency in the health care sector. During the 118th Congress, the House of Representatives passed the Lower Costs, More Transparency Act by a wide bipartisan margin, which would have provided for increased price transparency for health plans, as well as for hospitals, ASCs, clinical laboratory tests, and imaging services, among other provisions.²

The Committee’s legislative work builds on regulatory actions taken to enhance price transparency for hospitals and insurers. In 2019, under the Trump Administration, CMS issued a final rule requiring hospitals to post standard charges, including payer-negotiated rates and minimum/maximum rates, for certain items and services furnished in their facilities.³ While the Department of Health and Human Services (HHS) was sued to block the final hospital price transparency (HPT) rule, a judge ultimately dismissed the challenge, and the rule took effect in 2021.⁴ The Trump Administration—through HHS, as well as the Departments of Treasury and

¹ See, *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape: Hearing before the Subcomm. on Health of the H. Comm. on Energy and Commerce, 119th Cong. (Mar. 18, 2026)*.

² Lower Costs, More Transparency Act, H.R. 5378, 118th Cong. (2023).

³ Final rule, 45 Fed. Reg. 180.50 (Nov. 27, 2019) (Requirements for making public hospital standard charges for all items and services, which was published on November 27, 2019, and was to be effective on January 1, 2021).

⁴ *The American Hospital Association v. Alex M. Azar II, Secretary of Health and Human Services* (D.C. Cir. 2020) (Nichols, U.S. District Judge).

Labor—also proposed the Transparency in Coverage rule in 2019.⁵ This rule was finalized in November 2020 and set forth requirements that group health plans and health insurance issuers disclose to individuals estimated cost-sharing liability for covered items and services, and it required plans to disclose in-network negotiated rates, historical out-of-network allowed amounts, and drug pricing information through separate machine-readable files.⁶

In November 2024, HHS’s Office of Inspector General issued a report estimating that 46 percent of all eligible U.S. hospitals were not complying with the HPT rule requirements.⁷ Wall Street Journal coverage following the finalization of the rule found that several hospitals were allegedly blocking access to HPT data on their websites by leveraging “search-blocking” code embedded in the websites.⁸ A recent analysis has shown that, while hospitals may generally be complying with the HPT final rule, a significant percentage of price transparency data is still inaccessible or unusable for purposes of empowering patients to compare costs.⁹ To date, CMS has assessed noncompliance penalties for only 28 hospitals.¹⁰ With respect to Transparency in Coverage data, stakeholders have noted some barriers to using this data due to file sizes and formats, ghost or zombie rates, and application programming interfaces issues, among other challenges.¹¹

In February 2025, the Trump Administration issued an Executive Order (EO) building on their price transparency work by instructing the tri-agencies to enhance existing price transparency requirements, strengthen enforcement, and further patient access to meaningful pricing information.¹² Consistent with this EO, the Calendar Year 2026 Outpatient Prospective Payment System final rule made changes to HPT regulations, which are intended to improve the accuracy and usability of this data for consumer and other users.¹³ In December 2025, CMS, in partnership with the Departments of Labor and Treasury, also issued proposed changes to

⁵ Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services; Transparency in Coverage, 84 FR 65464 (proposed Nov. 27, 2019).

⁶ Final rule, 85 FR 72158 (Nov. 20, 2020) (Transparency in Coverage, which was published on November 20, 2020, and took effect January 11, 2021).

⁷ OFFICE OF INSPECTOR GENERAL (OIG), Department of Health and Human Services (HHS), *Not All Selected Hospitals Complied With the Hospital Price Transparency Rule* (Nov. 2024), <https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf>.

⁸ Tom McGinty et al., *Hospitals Hide Pricing Data from Search Results*, WALL STREET JOURNAL (Mar. 22, 2021), <https://www.wsj.com/health/healthcare/hospitals-hide-pricing-data-from-search-results-11616405402>.

⁹ Charles Ogles et al., *Compliance and Barriers in Hospital Price Transparency: A Cross-Sectional Evaluation of Alabama Hospitals With Emphasis on Spinal Surgery*, CUREUS (Feb. 27, 2026), <https://www.cureus.com/articles/466707-compliance-and-barriers-in-hospital-price-transparency-a-cross-sectional-evaluation-of-alabama-hospitals-with-emphasis-on-spinal-surgery#!/>.

¹⁰ CTRS. FOR MEDICARE & MEDICAID SERVICES (CMS), Hospital Price Transparency, *Enforcement Actions*, <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions> (last accessed June 4, 2026).

¹¹ Alice Y. Choi, et al., CONG. RSCH. SERV. (CRS), R48570, [Technical Challenges with Private Health Insurance Price Transparency Data](#) (2025).

¹² Exec. Order No. 14221, 90 Fed. Reg. 11005 (Feb. 25, 2025).

¹³ CMS, Fact Sheets, *CY 2026 OPPIs and Ambulatory Surgical Center Final Rule - Hospital Price Transparency Policy Changes* (Nov. 21, 2025), <https://www.cms.gov/newsroom/fact-sheets/cy-2026-oppi-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes>.

strengthen price transparency requirements with the similar goal of increasing the usability, accessibility, and impact of price transparency data for consumers and purchasers.¹⁴

IV. LEGISLATION

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

This discussion draft would require hospitals to post, in a machine-readable file, information about the standard charges and prices for each item and service furnished by the hospital for each year, including a plain language description of each item or service accompanied by its code or identifier; the gross charge, expressed as a dollar amount; 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. The discussion draft would provide for civil monetary penalties for noncompliance as part of an enforcement process, which may also include waivers or reduced penalties for hospitals in rural or underserved areas or for hospitals that waive their right to a hearing.

The policy would similarly require that ASCs, as well as clinical laboratory tests and imaging services, comply with certain price transparency requirements to make public standard charges or prices, discounted cash prices, or gross charges, as applicable.

The discussion draft would also require commercial health plans to provide enrollees, through a self-service tool, information on items and services for which benefits are available. This would include information related to in-network rates for participating providers; estimated cost-sharing; frequency or volume limitations for an item or service; any applicable utilization management; financial incentives available to the individual for an item or service furnished by such provider; and information in the case of applicable spread price drugs.

Commercial health plans would also be required to make available in separate machine-readable files certain rate and payment information, including in-network rates for items and services for participating providers; information about in-network drug rates for each drug covered under the plan, as well as the average amount paid for a drug dispensed or administered during the applicable period; and information related to the amount billed and amount allowed by the plan for items and services furnished by a provider that was not a participating provider. Plans would be required to make public a data file containing a summary of rate and payment information made public by the plan or issuer for a plan year.

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

This discussion draft would require hospitals to post on the walls of such hospital the discounted cash price of CMS-specified shoppable services furnished by the hospital.

¹⁴ Transparency in Coverage, 90 Fed. Reg. 60432 (proposed Dec. 23, 2025); *see also*, CMS, Fact Sheet, *Transparency in Coverage Proposed Rule* (CMS 9882-P) (Dec. 19, 2025), <https://www.cms.gov/newsroom/factsheets/transparency-coverage-proposed-rule-cms-9882-p>.

C. 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.]

This discussion draft would require Medicare Advantage (MA) plans and health insurance issuers offering group or individual health insurance coverage to submit to the Secretary and publish on the organization or issuer's public website in a consumer-friendly format information regarding the percentage of total premium revenue expended on reimbursement for clinical service claims, quality improvement activities, and non-claim costs, as well as the percentage of total premium revenue not expended or retained by the issuer.

D. 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.]

This discussion draft would require MA plans and commercial health plans imposing any prior authorization to submit to the Secretary and make available on the public website of the organization or plan the following information regarding their use of prior authorization:

- A list of all items and services subject to a prior authorization requirement under the plan or coverage during the plan year.
- The percentage and number of prior authorization requests approved and denied during a plan year in an initial determination.
- The percentage and number of prior authorization requests denied during a plan year that were appealed.
- The percentage and number, by category and level of appeal, of resolved appeals that resulted in an approval of the item or service.
- The average and the median amount of time between the submission of a prior authorization request and a determination by the plan.

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

This legislation would require hospitals to post in a machine-readable file and on a monthly basis information about the standard charges and prices for each item and service furnished by the hospital, including a plain language description of each item or service accompanied by its code or identifier; the gross charge, expressed as a dollar amount; the discounted case price; payor-specific negotiated charges, including the algorithm, percentage of another amount, or other formula or criteria if used by such hospital; 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. The legislation would provide for civil monetary penalties for noncompliance as part of an enforcement process.

The policy would similarly require that specified ASCs, as well as clinical laboratory tests and imaging services, comply with certain price transparency requirements to make public standard charges or prices, discounted cash prices, or gross charges, as applicable.

The legislation would also require commercial health plans to provide enrollees, through a self-service tool, information on items and services for which benefits are available. This would include information related to in-network rates for participating providers; the amount of

cost-sharing; frequency or volume limitations for an item or service; and applicable utilization management. The bill requires that a member of the plan utilizing the self-service tool would be held harmless for any cost exceeding the amount of the individual's responsibility generated by the self-service tool.

Commercial health plans would also be required to make available in three separate machine-readable files certain rate and payment information, including in-network rates for items and services for participating providers; information about in-network drug rates for each drug covered under the plan, as well as the historical net price for a drug dispensed or administered during the applicable period; and information related to the amount billed and amount allowed by the plan for items and services furnished by a provider that was not a participating provider. The legislation also includes certain requirements for file submissions pertaining to file size, format, data elements, and other disclosures to determine the dollar value of reimbursement. The legislation further includes certain enforcement requirements (e.g., audits, corrective plans, and civil monetary penalties).

The bill would prohibit contracts or arrangements for services with certain entities unless the contract or arrangement provides access to all claims data, encounter data, and supporting documentation.

The legislation would further establish certain oversight and disclosure requirements for administrative service providers, including a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party.

The legislation would preempt state law to the extent specified price transparency requirements that would apply under this bill conflict with state law.

The legislation would also require commercial health plans to provide the enrollee with certain information within 45 days of receiving any request for payment for an item or service under the plan regarding whether the provider is in network, along with an itemized explanation of benefits.

Moreover, the bill requires that a health care provider or health care facility that is requesting payment for an item or service provide an itemized bill of the cost of each reasonably expected item or service the provider provided to the individual within 30 days of receiving final payment from a third party, including a plain language description of each item or service; the applicable billing codes and the price and billed amount; and any payments made to the provider by or on behalf of the individual, among other information.

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

The legislation would provide certain oversight and disclosure requirements for administrative service providers, including a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party.

The legislation would also require commercial health plans to provide the enrollee with certain information within 45 days of receiving any request for payment for an item or service under the plan regarding whether the provider is in network, along with an itemized explanation of benefits.

Moreover, the bill requires that a health care provider or health care facility that is requesting payment for an item or service provide an itemized bill of the cost of each reasonably expected item or service the provider provided to the individual within 30 days of receiving final payment from a third party, including a plain language description of each item or service; the applicable billing codes and the price and billed amount; and any payments made to the provider by or on behalf of the individual, among other information.

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

This discussion draft would require that any encounter data submitted by an MA plan include the allowed amount for an item or service, the amount of cost sharing imposed for such item or service, and whether an at-home health risk assessment was furnished by an assessment entity or specified assessment entity.

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

This discussion draft would require certain specified entities to submit to the Secretary an annual report containing information about such entity's business structure; data on mergers, acquisitions, and changes in ownership in the last year; information on the parent company or owners of the parent company of the specified entity; and certain additional information when the specified entity is, or includes, a hospital. The Secretary would annually post a public report on these specified entities and conduct audits or penalize entities who do not report the information required by the discussion draft.

I. 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 organizations.]

This discussion draft would require the Secretary to establish a maximum compensation amount for an agent, broker, or other third part representing MA organizations for enrolling an individual into a plan. MA organizations would also be required to report annually whether individuals enrolled in such organization's plan(s) were enrolled by an agent or broker and the compensation received by the agent or broker. The Secretary would be required to make available in the CMS Chronic Conditions Data Warehouse or to the public certain information reported under this discussion draft.

VI. STAFF CONTACTS

If you have questions regarding this hearing, please contact Claire Richey of the Majority Committee staff at (202) 225-3641.