AMCP
Optimizing medicine.
Improving lives.

July 27, 2026

House Energy and Commerce Committee Advances the Lower Costs, More Transparency Act of 2026

Overview:

On July 20 and 21, the House Energy and Commerce Committee held a markup of 29 bills pertaining to energy permitting, critical minerals, illicit drugs, and health care price transparency. This includes the Lower Costs, More Transparency Act of 2026 (H.R. 9393), a comprehensive price transparency and health care affordability package led by Chairman Brett Guthrie (R-KY) and Ranking Member Frank Pallone (D-NJ). The bill would codify and amplify existing hospital health price transparency regulations promulgated by the Department of Health and Human Services (HHS), while also extending such mandates to ambulatory surgical centers, clinical laboratories, and imaging facilities. Commercial health plans would also be required to post information publicly on benefits and payment rates for in and out-of-network providers. This version of the bill was unanimously reported favorably to the full committee by the Energy and Commerce Health Subcommittee during a June 25 markup. During the full committee markup on July 21, Chairman Guthrie offered an amendment in the nature of a substitute that tacked language from several other health care bills onto the Lower Costs, More Transparency Act of 2026. This includes language on prior authorization reporting requirements (H.R. 9396, H.R. 9397), additional reporting requirements for Medicare Advantage plans (H.R. 3514, H.R. 5243), expediting the approval of biosimilar biologic therapies (H.R. 5526, H.R. 9661), citizen petitions (H.R. 8908), nonprescription drug approvals (H.R. 9774), and community health center services ((H.R. 8201, H.R. 9389). The Guthrie substitute amendment was agreed to by a voice vote. Rep. Buddy Carter (R-GA) offered an additional amendment to the Lower Costs, More Transparency Act of 2026 that would've included language regulating vision benefit managers (H.R. 1521), but he withdrew it following a commitment from Chair Guthrie to consider the issue later this term. Rep. John James (R-MI) also offered an amendment borrowing from his Patients Deserve Price Tags legislation (H.R. 5582) that would've required plans and providers to offer patients an Explanation of Benefits statement and a detailed itemized bill. Rep. James subsequently withdrew his amendment but expressed frustration that his bill was not considered by the committee.

The committee reported the Lower Costs, More Transparency Act of 2026, as amended, favorably to the full House of Representatives in a unanimous vote, 42 yeas to 0 nays. This marks the second consecutive Congress to have put a Lower Costs, More Transparency Act up for consideration by the House of Representatives. In 2023, the House passed the Lower Costs, More Transparency Act of 2023, which included similar hospital and insurer transparency mandates along with significant reforms to the business practices of pharmacy benefit managers, in a bipartisan fashion. While the previous bill stalled at the end of the 118th Congress, the 119th Congress has reinvigorated the push to pass health price transparency and affordability legislation ahead of the 2026 midterm elections this November, in an effort to assuage voter concerns with rising prices nationwide. During the markup, the Energy and Commerce Committee also reported an additional hospital price transparency bill (H.R. 9390),

legislation on illicit drugs (H.R. 1266, H.R. 7970, H.R. 1561, H.R. 8005), and a proposal to provide schools with opioid reversal drugs (H.R. 7994) favorably to the full House of Representatives as standalone bills. A summary of the Lower Costs, More Transparency Act of 2026 continues below.

Title I – Health Care Price Transparency

Title I of the Lower Cost, More Transparency Act of 2026 would codify and expand upon existing transparency and reporting requirements for hospitals. Starting in 2029 and annually thereafter, hospitals would be required to compile and publish information on standard charges and prices for at least 300 Centers for Medicare and Medicaid Services (CMS) -specified shoppable items and services furnished as well as identifying ownership and merger information associated with each hospital. Hospitals would be required to publish a plain language description of each item or service accompanied by billing code; the gross charge and discounted cash price in dollar amount; payer-specific negotiated charges, associated with the specific payer; deidentified maximum and minimum negotiated charges; and other information that may be determined by HHS. By 2028, HHS would be required to establish a uniform, machine-readable reporting method and format for hospitals to publicly post charge and pricing information. HHS would also be required to establish a process for monitoring hospital compliance, which may include the use of audits and additional reporting metrics. Noncompliant hospitals that fail to carry out corrective action plans would be subject to civil monetary penalties, tailored to a hospital's size, from HHS. Exemptions, waivers, or reduced penalties would be made eligible to certain hospitals servicing rural or underserved patients or experiencing hardships such as a public health emergency or natural disaster. HHS would also be required to publish information on its compliance and enforcement efforts beginning in 2028. These transparency and reporting requirements would also extend to services and items furnished at ambulatory surgical centers, clinical laboratories, and for diagnostic imaging services.

Title I of the Lower Costs, More Transparency Act of 2026 would also establish requirements for commercial health plans to publish annual rate and payment information in machine-readable files, as well as benefits information through an online self-service tool. Starting in 2028, the self-service tool must display comparable information on the amount of cost-sharing for each item or service covered. This includes in-network rates for participating providers and maximum payments for out of network providers; the estimated amount of deductibles, copays, and coinsurance a beneficiary would incur for an item or service; the amount a beneficiary has already accrued towards their deductible, frequency limitation, or volume limitation; any utilization management, including prior authorization and step therapy, requirements applicable; and financial incentives available to the beneficiary. The self-service tool must also include information on drugs covered under a spread pricing arrangement, including the total spread and a description of the practice of spread pricing. As previously mentioned, commercial insurers would also be required to publicly post rate and payment information on items or services covered–including prescription drugs–starting in 2028. Such information would include in-network rates for each covered item or service for a one-year period beginning 18 months before publication, the average amount paid for each drug for a 90-day period beginning 180 days before publication, information on spread price drugs, and the amount allowed for items or services furnished by nonparticipating providers. Rate and payment information must be published in machine-readable files on a publicly available website, complete with user instructions. Plans must also compile an annual summary of rate and payment information made public in the previous year, in a machine-readable file, which includes average in-network rates and allowable payment amounts for nonparticipating providers, trends in payment rates, a description of the plan and its participating

provider network, information on capitated payment rates, and the percentage of items and services covered on a fee-for-service basis. Plans must also annually publish ownership information and attest to the accuracy of required disclosures. To comply with the spread pricing provisions of this title, PBMs would be required to disclose, in a manner to be determined by HHS, a list of drugs covered by spread pricing arrangements, as well as the total 'spread,' or difference between the amount paid to the pharmacy and charged to the plan, for each such drug. By 2028, HHS would be required to publish a report on the use of application programming interfaces to facilitate access to health care transparency information, including the current use of such interfaces by federal agencies and the feasibility of using them to transmit information required under this title. Within a year of enactment, HHS would also be required to publish a report on the feasibility of creating a provider tool, in a manner similar to the patient self-service tool, to allow for provider access to rate and payment information. The bill would also require additional reports to Congress on compliance and the potential future inclusion of quality data into the bill's reporting requirements.

The substitute amendment passed on July 21 also includes an additional oversight provision for pharmacy benefit managers and other third-party administrative service providers (collectively referred to as 'health plan service providers') contracted with commercial plans. The bill would prohibit the use of gag clauses starting one year after enactment, mandating that any third-party administrative contract with a plan may not prevent the disclosure of information by health plans as required under this title. Beginning two years after enactment, and recurring every six months afterwards, health plan service providers must disclose information to plans on claim-related financial obligations, contractual calculation methodologies, the total amount of remuneration (including rebates, fees, and discounts) received by the health plan service provider and paid out for claims or services incurred, the total amount paid by the health plan service provider to subcontractors in rebates, fees, or all other remuneration, and all payment data related to alternative compensation arrangements including accountable care organizations, value-based programs, capitation arrangements, and all other arrangements where a plan paid fees to the service provider. Health plan service providers must disclose information to plans in a manner consistent with existing patient privacy protections and information disclosure formats. HHS would be granted the authority to impose civil monetary penalties on service providers that violate this section.

Finally, Title I of the Lower Costs, More Transparency Act of 2026 would require HHS to publish a report, annually from 2029 to 2033, on the ownership information of hospitals, clinical labs, imagining service providers, ambulatory surgical centers, and physician practices. The report would include the total number of entities operating in the U.S., the business structure of each entity, the type of organization of each entity, the number of owners of an entity, changes in ownership or tax status over a period, and an analysis f horizontal and vertical integration trends among such entities.

Title I would appropriate $20,000,000 for Fiscal Year (FY) 2026 for implementation purposes.

Title II – Insurance Accountability

The substitute amendment of the Lower Costs, More Transparency Act of 2026 inserted a number of additional bills affecting prior authorization and Medicare Advantage plan. Borrowing from language in the Prior Authorization Accountability Act (H.R. 9396), Title II would require commercial health plans that impose prior authorization requirements to compile annual reports on prior authorization practices and trends, to post publicly and submit to HHS starting in 2028. Such reports must include:

- a list of *all* items and services subject to prior authorizations 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 denials that were appealed;
- the percentage and number of resolved appeals that resulted in coverage for an item or service, categorized by item or service;
- the percentage and number of prior authorization denials and approvals carried out by decision support technology, artificial intelligence, machine-learning technology, or other technology as determined by HHS, as well as a disclosure regarding any such technology utilized;
- the average and median time elapsed between a prior authorization request and determination, excluding requests with insufficient information; and
- the total number of complaints or grievances received by a plan regarding prior authorization requirements and parameters.

Additionally, Title II includes language from the Premium Transparency Act (H.R. 9397). This provision would require both group, individual, and Medicare Advantage plans to report on the percentage of premium revenue expended on reimbursement for services, activities to improve care quality, and all other non-claim costs, as well as the percentage of premium revenue not expended or retained by the insurer. Such plans must submit their data to HHS and post them on a publicly available website, starting in 2028. The Affordable Care Act's requirement for a plan comparison website would be amended to require the inclusion of data mandated under this title. This provision also instructs HHS to develop guidance on a standard, plain English format for insurers to provide information on cost sharing amounts, plan type, availability of patient support, and other coverage details by 2028.

Title II also includes text from the Improving Seniors' Timely Access to Care Act (H.R. 3514), affecting additional prior authorization, transparency, and enrollee protection requirements for Medicare Advantage Plans, starting in 2028. This provision would require Medicare Advantage plans to establish an electronic prior authorization platform. It would also extend the prior authorization reporting requirements found in H.R. 9396, including information on prior authorization denial and approval rates and items and services subject to prior authorization, to Medicare Advantage plans. Importantly, Part D drugs are not considered "applicable items or services" under this provision, while *all* items and services subject to prior authorizations are considered applicable under commercial plan prior authorization reporting requirements. This Medicare Advantage provision would also codify enrollee protection standards, directing plans to adopt a transparent prior authorization program in consultation with enrollees and providers; allow for a waiver of prior authorization requirements based on provider performance; and conduct annual reviews of prior authorization requirements with feedback from stakeholders. Within two years of the submission of data, the Medicare Payment Advisory Commission would be directed to develop a report to Congress on the use of prior authorization, as well as recommendations for improving electronic prior authorization. This section also clarifies HHS' authority to establish real-time and expedited prior authorization determination parameters, by requiring CMS to develop a report that establishes a definition for real-time prior authorization decisions; details a process for real-time decisions of routinely approved items or services, which HHS may decide to require Medicare Advantage plans to implement; and includes an analysis of items and services routinely approved or appropriate for real-time decisions, by 2032. This section would also require Medicare Advantage plans to include information on allowed amounts for

items or services, cost sharing amounts, details on in-home health assessments, and when submitting encounter data for plan years starting in 2028.

Finally, Title II incorporates the Medicare Advantage supplemental benefit transparency provisions found in H.R. 5243. This section would require Medicare Advantage plans, starting in 2029, to submit enrollee-level data on supplemental benefits to HHS. Such data must include eligibility parameters and utilization and payment information. HHS would be required to make such information public within two years of a plan's data submission.

Title II would appropriate $40,000,000 for FY 2026 for implementation purposes.

Title III – Lowering Drug Prices

Title III of the Lower Costs, More Transparency Act of 2026 was also included as part of the amendment in the nature of a substitute passed on July 21. It includes language on biosimilar drug therapies, citizen petitions, and nonprescription drugs. Sec. 301, which includes text of the Biosimilar Red Tape Elimination Act (H.R. 5526), would eliminate the existing statutory requirement for biosimilar therapies to demonstrate interchangeability, while designating all FDA-approved biosimilars as interchangeable to their reference product upon approval. This would eliminate the need for biosimilars to undergo switching studies before receiving a designation as interchangeable. This provision would go into effect on the date of enactment, both for products approved prior to enactment, and for those approved after. However, this section includes a cooldown period for biologics with exclusive interchangeability status in effect on the date of enactment, which would allow for such periods to remain in effect for their full duration. This section directs the Food and Drug Administration (FDA) to issue, revise, and or revoke guidance relating to the approval of biosimilar biologic products within 18 months of enactment.

Title III also includes biosimilar provisions from the Expedited Access to Biosimilars Act (H.R. 9661), which would clarify that additional clinical studies on pharmacodynamics and comparative efficacy are not required for a biosimilar to receive FDA approval if existing scientific data justifies licensure. FDA would retain the authority to require such additional studies only if deemed necessary to demonstrate safety and effectiveness, but must notify manufacturers of a requirement for additional studies no later than 60 days after an approval application is submitted.

Finally, Title III includes text from the STOP GAMES Act (H.R. 8908), pertaining to FDA citizen petitions, and the Nonprescription Drug Innovation Act (H.R. 9774), pertaining to the expedited development of nonprescription drugs. This section would place additional requirements on the submission of citizen petitions to the FDA, including a 60-day window for plaintiffs to submit petitions upon learning of the information that justifies such a petition. The FDA would be granted additional discretion in denying citizen petitions if it determines that such a petition was filed in an effort to delay the market entry of a generic competitor product. HHS may issue guidance on the factors that determine if a petition was filed to delay entry, including unreasonably delayed petitions, petitions filed near the time of patent expiration, those substantially similar to prior petitions, and other relevant considerations determined by the FDA. The section on nonprescription drugs would establish a "priority nonprescription drug" designation for nonprescription drug applications that meet certain criteria, such as an intended use for a novel nonprescription indication with a public health benefit, being a new molecular entity, or containing an active ingredient not already available in nonprescription form. The FDA would be required to facilitate the development and expedited review of products with priority nonprescription

drug designations. HHS must publish a list of the potential conditions in which treatment would be considered a meaningful public health benefit within 18 months after enactment.

Title IV – Expanding Access to Care

Title IV of the Lower Costs, More Transparency Act of 2026 includes provisions that would expand services offered by federally qualified health centers. This title would require health centers to offer behavioral and mental health and substance use disorder services as part of its statutorily required primary health services and is also found within H.R. 8201. Finally, this title would establish a Nutrition Education and Chronic Disease Prevention Initiative (as addressed in H.R. 9389) for federally qualified health centers, allowing the Health Resources and Services Administration (HRSA) to provide grants, contracts, or technical assistance to foster the inclusion of evidence-based nutrition education into primary care and workforce training. Health centers would be permitted to affiliate with academic medical centers or medical schools in carrying out these activities. HRSA would be required to prioritize health centers serving patient populations with poor nutrition or high rates of chronic disease in awarding grants. HHS would be required to develop a report to Congress on the use of funds within two years of enactment.

Title IV would appropriate in $250,000,000 each in implementation funding for FY 2027 and FY 2028 to implement the behavioral and mental health services provision, and $125,000,000 for FY 2027 and FY 2028 to implement the nutrition education initiative.

7/21/26 Markup Recording:

- https://energycommerce.house.gov/events/full-committee-markup-9