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Congressional Committees Advance Broad Health Care Legislation Before August Recess

Key Takeaways:

- Congressional committees advanced an unusually broad package of bipartisan health care legislation before the August recess, with hospital price transparency emerging as the dominant policy theme. Multiple committees in both the House and Senate approved legislation expanding transparency requirements for hospitals, health plans, Medicare Advantage organizations and other providers.
- Transparency efforts now extend well beyond hospital pricing. Committees also approved legislation requiring greater disclosure of prior authorization practices, Medicare Advantage supplemental benefits, insurer premium spending, tax-exempt hospital community benefit activities and utilization of the 340B Drug Pricing Program.
- Several longstanding bipartisan priorities continued to gain momentum. Bills addressing electronic prior authorization, expanded community health center services, faster approval of biosimilars, opioid overdose prevention and pharmacy benefit manager reforms all advanced with bipartisan support, suggesting meaningful opportunities for enactment.
- Although appropriations and fiscal legislation will dominate the September congressional agenda, many of these health care measures have a realistic path forward during a post-election lame duck session, particularly those with broad bipartisan committee support.

As the U.S. House of Representatives and the United States Senate prepared to go on break during August, several committees acted on significant health-related legislation. In this alert, we summarize the health care legislation advanced by House and Senate committees before the August recess and identify key transparency, prior authorization, Medicare Advantage, biosimilar and other policy proposals to watch.

House of Representatives

Committee on Energy and Commerce

The Committee on Energy and Commerce reported 29 bills, many covering health care issues. The Committee votes were bipartisan. The most relevant bills are:

Related People

- Julius W. Hobson, Jr.
- Mark W. Weller
- Steve Stranne
- Michael M. Gaba
- Ronke Fabayo
- Sylvia Kornegay

Related Capabilities

- Public Policy
- Health Care

- **H.R. 9774, HERO Act**: Would establish a competitive grant program to provide schools with opioid overdose reversal drugs.
- **H.R. 9393, Lower Costs, More Transparency Act of 2026**: 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 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 cash price; payor-specific negotiated charges; and de-identified maximum and minimum negotiated charges. The Centers for Medicare & Medicaid Services (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, 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 bill would similarly require that ambulatory surgical centers (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 bill would also require commercial health plans to provide enrollees, through a self-service tool, information on terms 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 items and services 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.

- **H.R. 9397, Premium Transparency Act**: Would require Medicare Advantage (MA) plans and certain commercial health plans 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. The bill would also require the Secretary to issue guidance to MA plans and commercial health plans on providing information on certain benefits and coverage under the plan in a standardized, plain-English format.
- **H.R. 9396, Prior Authorization Accountability Act**: Would require commercial health plans imposing any prior authorization requirements 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.
    - The percentage and number of prior authorization requests denied and approved by the plan solely through the utilization of decision support technology, artificial intelligence, machine learning, clinical decision-making technology or other technologies specified by the Secretary.
    - A disclosure and description of any technology described above that the plan utilized during the plan year in making determinations about prior authorization requests.
- **H.R. 3514, Improving Seniors' Timely Access to Care Act of 2025**: Would require MA plans that impose any prior authorization requirement on an applicable item or service to establish an electronic prior authorization program and meet certain enrollee protection standards. The bill would also require MA plans to meet certain reporting requirements regarding the plan's use of prior authorization, which would be published by the Secretary on the CMS website.
- **H.R. 9392, Medicare Advantage Cost Transparency Act**: 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.R. 5243, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage**: Would require enrollee-level utilization reporting of supplemental benefits by Medicare Advantage plans. This legislation was amended at the Subcommittee on Health Markup on June 25 to incorporate technical changes.
- **H.R. 8201, Expanding Community Access to Health Services Act**: Would include behavioral and mental health and substance use disorder services as required services offered by community health centers.
- **H.R. 9661, Expedited Access to Biosimilars Act**: Would eliminate the statutory requirement that sponsors of biosimilar applications conduct assessments of pharmacodynamics, immunogenicity and comparative clinical efficacy for licensure.

Committee on Oversight and Government Reform

- **H.R. 6610, the Pharmacists Fight Back [in Federal Health Benefit Plans Act]**: Would amend Chapter 89, Title 5, to limit the costs of pharmacy benefit managers with respect to federal employee health benefit plans; the bill was reported 40-2.

Committee on Ways and Means

- **H.R. 9504, Tax Exempt Hospital Transparency Act**: Would require hospitals with tax-exempt status to report additional details on the existing IRS Form 990, which details charity care, community health needs assessments and facility policies. The new reporting requirements include a CMS certification number for each hospital facility within a nonprofit hospital's network, the value of financial assistance provided, the number of completed financial assistance applications received, granted and denied, spending and actions taken to address the three highest priority health needs identified in the most recent Community Health Needs Assessment, as well as the amount of spending on quality improvement, nonclinical programming and advertising costs. Additionally, certain nonprofit hospitals would have to provide information on their health service lines and use of the 340B Drug Discount Program.

United States Senate

Committee on Health, Education, Labor and Pensions

- **S. 4189, INSULIN Act of 2026**: Would cap the cost of insulin at $35 a month for diabetes patients on private insurance; reported 17-5.
- **S. 2355, Patients Deserve Price Tags Act**: Would strengthen requirements for hospitals, laboratories, imaging centers and outpatient surgical centers to disclose cash prices and insurer-negotiated rates. A hospital executive would have to sign off on the prices. Providers out of compliance would face fines. Would also require insurers to disclose claims and usage data in employer-offered group health plans; reported 21-1.
- **S. 1414, Expedited Access to Biosimilars Act**: Would amend the Public Health Service Act to remove mandatory requirements for clinical studies to assess immunogenicity, pharmacodynamics, or comparative clinical efficacy for biosimilar drug approval; agreed to by Roll Call Vote, 22-0.

Outlook

The strong bipartisan committee votes on most of these measures significantly improve their prospects for eventual enactment. Many of these proposals—particularly those addressing hospital and insurer transparency, prior authorization, biosimilars and Medicare Advantage reporting—have accumulated bipartisan support over several Congresses and could be attractive candidates for inclusion in larger year-end legislative packages.

The principal exception remains the INSULIN Act of 2026 (S. 4189). The legislation was approved by the Senate HELP Committee on an 11-6 vote that suggests it could face more significant challenges on the Senate floor.

The Tax Exempt Hospital Transparency Act (H.R. 9504) warrants particularly close attention from nonprofit health systems. Beyond expanding IRS reporting requirements, the legislation increases congressional scrutiny of charity care, community benefit spending and utilization of the 340B Drug Pricing Program — issues that continue to receive bipartisan interest from policymakers.

Looking ahead, Congress is expected to devote most of September to appropriations and budget matters needed to avoid a government shutdown. As a result, floor consideration of these health care bills may be limited before the November elections. Nevertheless, bipartisan health care measures with broad committee support frequently serve as vehicles for year-end legislative packages, making the post-election lame duck session the most likely window for additional congressional action.