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MARKUP OF H.R. 1266, COMBATING ILLICIT XYLAZINE ACT;

H.R. 2004, TYLER'S LAW;

H.R. 7970, STOP NITAZENES ACT;

H.R. 1561, ALERT COMMUNITIES ACT;

H.R. 7994, HERO ACT;

H.R. 9389, NUTRITION EDUCATION AND CHRONIC DISEASE PREVENTION IN COMMUNITY HEALTH CENTERS ACT OF 2026;

H.R. 8201, EXPANDING COMMUNITY ACCESS TO HEALTH SERVICES ACT;

H.R. 9393, LOWER COSTS, MORE TRANSPARENCY ACT OF 2026;

H.R. 9397, PREMIUM TRANSPARENCY ACT;

H.R. 9396, PRIOR AUTHORIZATION ACCOUNTABILITY ACT;

H.R. 9390, PRICES ON THE WALL ACT OF 2026;

H.R. 3514, IMPROVING SENIORS' TIMELY ACCESS TO CARE ACT OF 2025;

H.R. 9392, MEDICARE ADVANTAGE COST TRANSPARENCY ACT;

H.R. 5243, TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO INCREASE DATA TRANSPARENCY FOR SUPPLEMENTAL BENEFITS UNDER MEDICARE ADVANTAGE; AND

H.R. 9395, TRANSPARENCY IN MEDICARE ADVANTAGE STEERING ACT

THURSDAY, JUNE 25, 2026

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 1:28 p.m. in Room 2123, Rayburn House Office Building, Hon. Morgan Griffith [chairman of the subcommittee], presiding.

Present: Representatives Griffith, Harshbarger, Bilirakis, Carter of Georgia, Joyce, Balderson, Miller-Meeks, James, Bentz, Houchin, Langworthy, Rulli, and Guthrie (ex officio); DeGette, Ruiz, Dingell, Kelly, Barragan, Schrier, Veasey, Ocasio-Cortez, Auchincloss, Carter of Louisiana, Landsman, and Pallone (ex officio).

Staff Present: Ansley Boylan, Director of Operations; Jessica Donlon, General Counsel; Sydney Greene, Director of Finance and Logistics; Jay Gulshen, Chief Counsel; Annabelle Huffman, Policy Analyst; Megan Jackson, Staff Director; Olivia Jensen, Staff Assistant; Noah Jackson, Clerk; Brayden Lacefield, Special Assistant; Joel Miller, Deputy Staff Director; Ryan Murphy, Director of Member Services; Lillian Noland, Clerk; Claire Richey, Clerk; Seth Ricketts, Clerk; Jackson Rudden, Clerk; Chris Sarley, Senior Director of Policy Services/Stakeholder Engagement; Emma Schultheis, Professional Staff Member; Timothy Trimble, Staff Assistant;

Katie West, Press Secretary; Nick Wooldridge, Professional Staff Member; Lydia Abma, Minority Policy Analyst; Jordan Antwi, Minority Intern; Shana Beavin, Minority Professional Staff Member; Ruth Campos, Minority Intern; Keegan Cardman, Minority Staff Assistant; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Saha Khaterzai, Minority Professional Staff Member; Alyssa Kimura, Minority Intern; Serena Klebba, Minority Staff Assistant; Una Lee, Minority Chief Counsel, Health; Brendan Lopez, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach, and Member Services; Hannah Treger, Minority Staff Assistant; and C.J. Young, Minority Deputy Communications Director.

*Mr. Griffith. The Subcommittee will come to order. The chairman recognizes himself for an opening statement.

Today's markup will further our efforts to lower health care costs for all Americans and safeguard our communities. It builds off our most recent hearing that examined several policy proposals to increase price transparency across the health sector, and builds on President Trump's initiatives to bring more transparency to our health system.

The markup also builds on the work this subcommittee did in passing the HALT Fentanyl Act, led by myself and Mr. Latta, and the SUPPORT Act for Patients and Communities Reauthorization Act led by Chairman Guthrie, both of which President Trump signed into law last year.

Health care costs remain one of the most important challenges facing American patients, families, and employers. Today's health system can be complex and difficult to navigate, leaving many Americans without clear information about the cost or quality of care they receive. Patients are often asked to make important decisions without clear information about what the costs are that they might face, whether a provider is in network, out of network, or what alternative treatment options might be available. Even those who carefully plan medical expenses can be surprised by bills that arrive weeks or months after receiving care. The current lack of transparency leaves patients in the dark and

limits their ability to make informed care decisions.

At a time when consolidation among insurers and providers continues to reduce competition and drive up prices, transparency serves as a potential solution to empower consumer choice, improve health care outcomes, and ultimately lower costs. That is why we need to continue to move these critical bills across the finish line. We understand -- we know there is more work that needs to be done to refine many of these bills between the subcommittee action today and the full committee markup. But this is something that has been important to both sides of the aisle, and I look forward to continuing our work.

One of the bills under consideration is the Lower Cost, More Transparency Act which is a continuation of our transparency work from last Congress. The bill codifies many of the regulations implemented by the Trump Administration and aims to bolster transparency and compliance. It does so by requiring hospitals and providers to publicly post prices for their services, and it standardizes information for these charges and services provided by these entities.

Some of the other transparency bills in front of us today will bring more accountability and visibility into commercial and Medicare Advantage insurance plans. Several relate to prior authorization so individuals can see the percentage of health claims approved or denied in a plan

year.

Another bill aims to bring transparency and premium dollar -- into premium dollars, which can help consumers better understand how plans are using their premium dollars. The medical loss ratio, or MLR, was created under the under the so-called Affordable Care Act, and it is the percentage of premium dollars spent by an insurance company on medical care outside of administrative costs or profits. As we heard in our health care affordability series hearings, there is a gaming of this accountability measure. Incorporating increased transparency into plans and premiums helps provide clarity as to where premium dollars are being spent by insurance companies, and how much of it is actually going toward beneficiary care.

Additionally, there are several bills under consideration that continue our efforts into the illicit drug space. One of the bills is the Combating Illicit Xylazine Act, which would classify Xylazine as a schedule 3 under Controlled Substances Act, while also protecting its legitimate use in large animal veterinary medicine. The bill is important to my district as a -- because, according to the National Cattlemen's Association, Virginia's 9th district is the largest cattle-producing congressional district east of the Mississippi, and my district is home to two veterinary schools.

Another important bill before us is Tyler's Law, which requires the Department of Health and Human Services, or HHS, to study and issue guidance on whether hospitals should implement fentanyl testing in routine emergency department drug screenings.

Lastly, we will consider a couple of bills involving community health centers, one of which is led by Vice Chairwoman Harshbarger. That bill would allow for some community health center funding to be used for nutrition education and chronic disease prevention initiatives. I look forward to continuing our work on these policies and advancing them to the full committee.

I now recognize Ranking Member DeGette for her five minutes for an opening statement.

Ms. DeGette.

*Ms. DeGette. Thank you so much, Mr. Chairman. The legislation that we are marking up today has a wide range and, frankly, is a long time coming, so I thank you.

The bills include critical policies to bring transparency to our health care system, improve care at community health centers, and enhance the public health response to the ongoing opioid epidemic. This includes the Lower Costs, More Transparency Act, which we have been working to improve and which will help begin to untangle the thicket of health care pricing. It also includes legislation

to make fentanyl test strips and opioid reversal medications more available, interventions that are proven to save lives.

We are marking up my bill, the Medicare Advantage Cost Transparency Act, which will require Medicare Advantage plans to report just how much they pay for your care and how much you pay for it, helping policy-makers get a handle on just what people are getting from their MA plans. And I am pleased that this has bipartisan support.

Unfortunately, though, we are also marking up a policy to criminalize a class of drugs, tossing out the possibility that they could have a medical use and guaranteeing prison time for people caught possessing it. Furthermore, we are moving ahead with these bills kind of haphazardly. It seems like technical feedback from agencies and CBO scores are an afterthought and we are rushing ahead, though I am not aware of any deadline for these bills. Two of these bills will result in Americans being put in prison, should they become law, and so I don't think we should rush it and I don't think it is a good way to legislate. Once the Democrats have the gavel to this committee again I guarantee we are not going to legislate in just a haphazard way.

There is also a glaring omission in this markup. Despite consensus from our witness panel on the importance of transparency and ownership of hospitals and physician practices and, frankly, a growing awareness on the part of

the entire health care community that we need more transparency, we are not marking up the bill that Representatives Schakowsky and Bilirakis introduced last Congress to provide exactly that.

I know that private equity firms, which buy up some hospitals and physician practices, don't want consumers to know that their doctor's business or hospital is actually private equity owned. So what are they afraid of and why is that opposition stymieing our committee's work to shine light in the American health care system?

I say enough. We need to move this critical transparency legislation forward so that policy-makers can get a handle on the impact of private equity in hospitals and health care, and so that consumers can understand who owns the place where they get care. And I am going to offer an amendment later to force the issue, but I would think we would be able to do this on a bipartisan basis.

I am glad we are moving some of these policies forward. Enshrining transparency requirements into law has been a long time in coming. So let's approach these issues fearlessly and deliberately, and let's get this done.

I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize the chairman of the first -- of the full committee. And it is the first in importance of committees.

*The Chair. It is the first committee.

*Mr. Griffith. I recognize Mr. Guthrie from Kentucky --

*The Chair. Thank you, Mr. Chairman. Thank you for your recognition. The first permanent committee and the most historic. So I want to thank you so much for -- to take a moment to recognize the great work that we as a Committee have done not only to mitigate the threat of illicit drugs flooding into the United States, but also support our fellow Americans who are battling substance use disorder.

While I am proud that both the HALT Fentanyl Act and the SUPPORT Act were signed into law last year, there is always much more that can be done, and we remain committed to a healthier and safer America. In this markup we will consider a bill that reduces the threat of xylazine and nitazenes. The bills before us today will help get threatening substances off our streets, as well as make our communities healthier and safer.

Today we are considering several bills focused on enhancing transparency in health care. This includes legislation to build upon the Trump Administration's historic price transparency regulations and take action on the President's great health care plan. These bills will help provide the tools that consumers and employers need to make health care more affordable and increase competition across the market, and build on the committee's many years of

bipartisan work to improve transparency in health care. Our markup today will reinforce the committee's leadership on the issues as we continue working on these policies with colleagues across the aisle and other House committees and the Senate to advance price transparency law into law.

I want to thank my colleagues for being here, and I consider the legislation before us, and I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Pallone of New Jersey, for his opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

Today the subcommittee will mark up 15 bills, and some of these bills make transparency reforms that I will support, as I am always willing to work on policies that advance the ball forward for consumers and patients, regardless of how small or incremental. However, I want to make clear to my Republican colleagues that these bills are not adequate to address the issue of health care affordability.

The truth is, Republicans have created a health care affordability crisis with their big, ugly bill that cut health care by $1 trillion, the largest health care cut in American history -- and by refusing to extend the ACA enhanced premium tax credit. Now, across the country Americans are seeing their health care costs double or even triple in one year. Hospitals are closing service lines and

facilities due to the big, ugly bill's hospital cuts.

And while we are going to need to address this crisis, I am pleased we are considering the Lower Costs, More Transparency Act today. This bill represents the work this committee has undertaken for several congresses and that I led in the previous Congress with former Chair Rodgers. And this legislation will empower consumers and employers with data on the prices hospitals charge and the rates insurers pay so that they can compare prices and save money on health care services.

I am also pleased we are considering several bills that will improve transparency of the Medicare Advantage program. These bills bring much-needed transparency to the MA program by requiring insurance companies to report data on supplemental benefits, spending on medical services, and broker compensation. They also improve transparency of prior authorization.

However, I am disappointed that this markup does not include a provider ownership transparency bill. This bill would require transparency around ownership of hospitals and physician practices, including for entities owned by private equity and venture capital firms. Without transparent ownership data, health care consolidation will continue unchecked, driving up costs for consumers and reducing access to care. And I believe we can't adhere -- or we can't

achieve any true transparency in health care without ownership transparency.

I am also pleased we are considering H.R. 8201, the Expanding Community Access to Health Services Act, which would require community health centers to offer behavioral health and substance use disorder services and provide funding for centers that don't already offer those services.

And finally, Mr. Chairman, H.R. 7970 raises serious concerns. As with similar bills this committee has considered in the past to mandate class-wide scheduling of a class of substances, these bills would have Congress directly put substances into the schedule by statute, bypassing the eight-factor scientific and medical review that the Controlled Substances Act normally requires before a substance is scheduled. Congress created this process for a reason. It draws on FDA and DEA expertise, includes a public comment period, and produces a reviewable record. These safeguards are designed to ensure that decisions with major consequences for medical research, patient access, and criminal liability rest on scientific evidence.

So I would urge the committee to withhold further action on this bill and simply direct DEI, DoJ and HHS to do their jobs and engage in a science-based process to determine appropriate scheduling of these substances.

But before I conclude, I just want to point out that a

number of the bills being considered still have not received technical assistance from the agencies with expertise on these issues. So we received technical assistance on some of the other bills only a couple of days ago, so we also need more time to consider feedback from stakeholders on many of these bills. So I hope we can spend more time after this markup working on these bills before rushing to a full committee markup on policies that, in my opinion, need more work.

But with that I yield back the balance of my time. Thank you, Mr. Chairman.

*Mr. Griffith. I thank the gentleman for yielding back, and I would agree with him that these bills need some more refinement before we go to full committee, and so we are going to continue to work on a number of issues.

And with that I now call up -- oh, wait a minute. I was about skip everybody else's right to do an opening statement. I remind members that, pursuant to committee rules, all members' opening statements will be made a part of the record. Are there further opening statements?

Seeing none, I call up H.R. 1266, and ask the clerk to report.

*The Clerk. H.R. 1266, a bill to prohibit certain uses of xylazine, and for other purposes.

*Mr. Griffith. Without objection, the first reading of

the bill is dispensed with, and the bill will be open for amendment at any point.

So ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I would now like to recognize myself to speak on H.R. 1266, Combating Illicit Xylazine Act.

I would like to offer my strong support for the Act which places Xylazine into schedule 3 of the Controlled Substances Act, while ensuring there is exemption for appropriate use within the veterinary and ranching industry.

Xylazine is a veterinary drug used to sedate large animals. It apparently does not have a legitimate use in humans -- I have some discussion about that -- yet bad actors are using xylazine by mixing it with fentanyl to make it far deadlier. It is critical that we pass the common-sense bill that takes large strides to protect the American public while ensuring veterinary access to the drug.

And I urge my colleagues to support the bill and now recognize the gentlelady from Colorado, who has an amendment at the desk.

*Ms. DeGette. DeGette_039.

*The Clerk. Amendment to H.R. 1266, offered by Ms. DeGette of Colorado. Page 2, strike lines 13 through 19 and insert the following. Section 3, adding Xylazine to schedule 5. Schedule 5 of section 202© of the Controlled Substances Act of 2021. U.S.C. 812 is amended, one, by striking "any compound mixture or preparation,'' and inserting (a), "any compound mixture or preparation,'' and 2, by adding --

*Mr. Griffith. Any objection to reading -- to waiving

the reading of the amendment?

Seeing none, the amendment is before us.

[The amendment of Ms. DeGette follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I recognize the gentlelady from Colorado, Ms. DeGette.

*Ms. DeGette. Thank you, Mr. Chairman. Mr. Chairman, I am concerned that this bill circumvents the DEA process for scheduling, and that it would arbitrarily schedule xylazine in schedule 3 with no scientific justification. Possession of a schedule 3 drug carries penalties up to 10 years for a first offense. Criminalization does not meaningfully deter drug use, and it is not the answer to our nation's substance abuse crisis.

Congress should either insist that DEA and HHS produce an eight-factor scientific analysis on xylazine to inform a scheduling decision, going about it the right way, or to place xylazine in schedule 5, making it in a controlled substance but possession of which is a misdemeanor offense, not a felony.

Mr. Chairman, as you said, xylazine is often used with fentanyl, but -- and so clearly, that is going to be a felony sentence. But for xylazine in and of itself, we need to have that analysis which is always used if we are going to make something a schedule 3 controlled substance.

I am told that the Biden Administration did produce an analysis, but it has never been released, even though the Ranking Member Pallone requested such an analysis in a September 4, 2024, letter. And I would ask unanimous consent

to put that in the record.

Without objection --

*Ms. DeGette. Advocates tell me --

*Mr. Griffith. -- so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Advocates tell me that the analysis recommended placing xylazine in schedule 5, but we are still waiting to see that.

And so what my amendment would do is it would place xylazine in schedule 5, rather than schedule 3, maintaining DEA's ability to track and prosecute misuse of xylazine while also protecting biomedical research and substance abuse treatment efforts. I suspect that it will also save Federal money that would otherwise be wasted over criminalizing xylazine, but we wouldn't know because we haven't yet seen a CBO score for this bill.

But in my experience, both when I was practicing law and also on this committee, if you over-schedule a offense, it is just going to cost a lot more, and it is going to put a lot more people in prison. And so I just would hope to work with you, Mr. Chairman, to get to a solution where we get the real expert analysis we need to make such a weighty decision that could have impact on people's lives, to look and see if we can get the eight-factor analysis. And I would hope you could work with me on this, Mr. Chairman.

*Mr. Griffith. I am more than happy to work with you and try to follow the science and figure out what is right. I agree -- I am glad that we agree that it needs to be scheduled and that we need to put it at some level, but we will see where we go when we get the analysis and look at all

the science and data.

*Ms. DeGette. Great. Thank you --

*Mr. Griffith. And I appreciate that.

*Ms. DeGette. -- so much. In that case I will withdraw the amendment based on your assurance that you will work with me.

*Mr. Griffith. The gentlelady has agreed to withdraw her amendment. Are there any further amendments to H.R. 1266?

Any further discussion on 1266?

I recognize the gentlelady from Washington, Dr. Schrier.

*Ms. Schrier. Thank you, Mr. Chairman.

I am glad that our subcommittee is considering the Combating Illicit Xylazine Act. As a doctor, I look at the worsening synthetic drug crisis through a medical lens. And what we are seeing with the rise of xylazine, or tranq, is incredibly alarming. This drug is devastating communities across the nation, and that includes my home state of Washington.

For decades, xylazine has had a safe and legitimate use in veterinary medicine to sedate large animals. But recently illicit drug traffickers have been using it as a cheap cutting agent for fentanyl. And because xylazine is a sedative and not an opiate, standard overdose reversal agents like Narcan don't work against it. So this makes an already

deadly fentanyl crisis even potentially more lethal and difficult to respond to and treat, which makes it a challenge for first responders. It also causes horrible skin lesions and other -- has other impacts.

My district covers everything from suburban neighborhoods to agricultural communities, and I know firsthand that farmers, ranchers, and veterinarians really rely on xylazine to safely handle injured or dangerous livestock. And so you have this dilemma where, on one hand, non-physicians have legitimate veterinary use for this, while on the other hand bad actors are using xylazine as a cutting agent for fentanyl and endangering people's lives. And so because of this, the drug can't really be effectively scheduled through DEA, and that means that we, as a body, have to act on this in order to regulate xylazine.

I am proud to sponsor this legislation which includes xylazine as a schedule 3 drug, and allows it to still be administered for safe veterinary purposes, and I would my encourage my colleagues to vote yes.

And I yield back.

*Mr. Griffith. The gentlelady yields back. Is there anyone else -- any further discussion?

I recognize the gentleman from Florida, Mr. Bilirakis.

*Mr. Griffith. Thank you. Thank you, Mr. Chairman. I appreciate it. I support, of course, H.R. 1266, the

Combating Illicit Xylazine Act, legislation I am proud to co-lead alongside my colleagues, Representatives Panetta, Pfluger, Papper, Fitzgerald -- Pappas, Fitzgerald, and Ross. But there were other cosponsors as well, like the good doctor over here.

Communities across our country continue to grapple with the devastating consequences of the illicit drug epidemic. As law enforcement and public health officials work to combat fentanyl and other dangerous substances, traffickers continue to adapt by introducing new and increasingly deadly addictives -- additives, in this case -- into illicit drug supply.

One of those substances is xylazine, a veterinary sedative that was never intended for human use. Drug traffickers have increasingly used xylazine as a low-cost cutting agent in fentanyl and other illicit drugs, creating mixtures that are more dangerous, more difficult to treat, and increasingly present in communities throughout the country, unfortunately.

Our laws must keep pace with these emerging threats, and that is what we are doing today. The Combating Illicit Xylazine Act would classify xylazine as a schedule 3 controlled substance, provide law enforcement with additional tools to track and combat its diversion into the illicit market, and require further reporting and analysis regarding

its prevalence and misuse.

At the same time, this legislation protects the legitimate use of xylazine by veterinarians -- we work with them -- and farmers, as well, ranchers and others who rely on this medication to treat large animals.

As drug traffickers continue to adapt and evolve, unfortunately, Congress must ensure that our laws and enforcement tools remain effective.

So with that, Mr. Chairman, I urge my colleagues to support this particular piece of legislation, and I yield back.

*Mr. Griffith. The gentleman yields back. Is there any further discussion on the bill?

Seeing none, the question now occurs on forwarding H.R. 1266 as to the full committee.

All those in favor, say aye.

All opposed, no.

The ayes have it. The bill is agreed to and forwarded to the full committee.

I now call up H.R. 2004, and ask the clerk to report.

*The Clerk. H.R. 2004, a bill to direct the Secretary of Health and Human Services to issue guidance on whether hospital emergency departments should be -- should implement fentanyl testing as a routine procedure for patients experiencing an overdose, and for other purposes.

Be it enacted --

*Mr. Griffith. If the gentleman -- without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I would like to offer my strong support for H.R. 2004, Tyler's Law. This legislation directs HHS to conduct a study on the utilization, costs, and potential benefits of fentanyl testing in hospital emergency departments.

So often the bills that we have before us are because we have run across something in the real-life world, and this is one of those bills. Tyler's name is -- Tyler's law is named after Tyler Shamash, who suffered from a fatal fentanyl poisoning after doctors failed to test for fentanyl when he was admitted to the hospital emergency room. This bill would help prevent this tragedy from occurring in the future by helping ensure providers are able to apply the best practices when treating cases of potential drug overdose.

I strongly urge my colleagues to support the bill, and I yield back. Does anyone else seek to be recognized to speak to the bill?

I see none. Oh, I recognize the gentlelady from Colorado, the ranking member of the sub, Ms. DeGette.

*Ms. DeGette. Thank you, Mr. Chairman.

Fentanyl and its ultra-potent analogs surpassed prescription opioids as the leading cause of overdose deaths a year ago -- or a decade ago. But our overdose prevention strategies just aren't keeping up. Recent years have seen great progress in point-of-care testing technology, meaning

that we have long-overdue lifesaving tools to treat fentanyl overdose, tools that could have saved the life of 19-year-old Tyler Shamash, who died of an overdose despite going to the hospital because neither Tyler nor his clinicians knew he had taken fentanyl.

Despite diagnostic advancements and the rising prevalence of illicit fentanyl, only a handful of states require emergency departments to test as part of their toxicology screenings. This bill would give us more information about the feasibility regarding fentanyl testing in emergency departments nationwide and direct HHS to issue guidance accordingly. And so we all, on this side, urge support of this. We support it strongly.

And we yield back -- I yield back.

*Mr. Griffith. Is there any further discussion on the bill?

Seeing none, the question now occurs on forwarding H.R. 2004 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

I now call up H.R. 7970. Would the clerk call up H.R. 7970?

*The Clerk. H.R. 7970, to amend the Controlled

Substances Act to permanently schedule two benzyl benzimidazole opioids as schedule 1 controlled substances, and for other purposes.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, that is so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I am going to offer strong support for this bill, as well, and urge all of my colleagues to join me in support of the policy.

This is the STOP Nitazenes Act. This legislation enacts class-wide scheduling for nitazine under schedule 1. This is a synthetic opioid that is similar to, but can exceed, the potency of fentanyl. They are not approved for any medical use in the U.S., and are likely to be abused in the same manner as other schedule 1 opioids. Though many nitazenes have been placed under schedule 1 of the Controlled Substances Act and three have been placed under control internationally, a class-wide scheduling is imperative to stem the flow of this dangerous substance.

Chemical suppliers, primarily located in China, have been skirting the law by introducing new nitazenes or analogs when one becomes more difficult to produce due to regulations or scheduling. This legislation is critical -- is a critical step to tightening the controls we have on the class of nitazenes and working towards a safer America. You all remember this is -- what they do is they change the formula just a little bit. We saw this with the analogs to fentanyl. And that way they can get around the law, and it makes it a whole lot easier for them, or -- to either skirt the law and get away with it, or to just bring it into the United States or elsewhere.

So I strongly urge my colleagues to support this bill, and I yield back and now recognize the gentleman from New Jersey, Mr. Pallone, for his five minutes.

*Mr. Pallone. Thank you, and I speak in opposition to the bill.

Mr. Chairman, let me start where I think every member of this subcommittee already agrees, that nitazene are -- or nitazenes, I should say, are dangerous. They are potent, and Americans using it illicitly are suffering and dying. And what I am concerned about is how this bill approaches the problem.

What the agencies should be doing is engaging in the approach Congress laid out in the Controlled Substances Act, which requires scientific and regulatory entities to collaborate on a science-based approach to drug scheduling. But instead, H.R. 7970 would permanently place an entire chemical class -- those that exist today and those not yet invented -- into schedule 1, and it would do so immediately. And I have three problems with this approach.

First of all, this structure-based scheduling -- this is structure-based scheduling, not science-based scheduling. For more than 50 years, the CSA has asked a basic question before a drug enters schedule 1, and that is does it actually have a high potential for abuse and no accepted medical use? And that answer has rested on an eight-factor scientific and

medical evaluation led by HHS and the FDA. But H.R. 7970 sets that evaluation aside for an entire class. Public health experts have warned for years that this rests on an unproven assumption that structurally similar molecules behave similarly, but they do not always. Scheduling by structure alone risks sweeping in a potential anecdote alongside the poison.

Now, secondly, this bill has no off ramp, and schedule 1 is where research has stopped. Once the substance is scheduled, there is no built in mechanism to remove it if research later shows it is harmless or even useful. And schedule 1 is precisely the category that makes that research hardest to perform.

The Government Accountability Office reviewing the fentanyl class-wide order documented that scientists face real obstacles studying schedule 1 drugs, including long delays in obtaining approval. And this warning is particularly significant for nitazenes because CDC has found that naloxone can reverse a nitazene overdose, but often only after repeated doses. Designing better reversal protocols means studying these compounds, and that work would make this -- I mean, it is harder to do with this bill, not easier.

Then third, this approach is not new. The DEA already has the authority to schedule nitazene compounds, and has been doing so on a temporary basis since 2020. So each time

we scheduled one compound, the illicit market answered with another, more potent one. Nitazenes themselves are partly a product of that dynamic in the next move in a game of chemical Whack-A-Mole.

A broad, non-partisan coalition has told Congress this repeatedly -- the Leadership Conference on Civil and Human Rights and its 240 member organizations, the Drug Policy Alliance, the Vera Institute of Justice, The Sentencing Project, Aids United, and law enforcement voices like the Law Enforcement Action Partnership -- and their message is consistent. Permanent, class-wide scheduling repeats the failures of the drug war while diverting resources from what drove overdose deaths drown down last year: naloxone, fentanyl test strips, and medications for opioid use disorder.

So just to be clear, schedule what the science directs us to schedule; build in a research pathway and an off ramp for substances later shown to be harmless; and pair any enforcement with the health investments championed by this committee. If we are serious about stopping nitazenes, let's give scientists the tool to understand them and not just give prosecutors the tools to charge them.

So I urge my colleagues to oppose this bill, as written, and I reserve the balance of my time, Mr. Chairman.

*Mr. Griffith. The gentleman yields back. Is there any

further discussion on the bill?

Okay, seeing no further discussion on the bill, the bill comes up for a vote.

All those in favor, say aye.

All opposed, no.

The ayes have it, and the bill is forwarded to the full committee for consideration.

All right, now I call up H.R. 1561 and ask the clerk to report.

*The Clerk. H.R. 1561, a bill to require, with respect to fentanyl and xylazine test strips, to authorize the use of grant funds for such test strips, and for other purposes. Be it enacted --

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone seek to be recognized on the bill?

All right. Nobody gave me a script on this one.

*Ms. DeGette. Chairman?

*Mr. Griffith. The gentlelady from Colorado.

*Ms. DeGette. Drug dealers often mix drugs with fentanyl to increase potency at low cost, which increases the likelihood of a fatal interaction. That is why testing unregulated drugs for fentanyl is a critical part of preventing overdoses. These tests are inexpensive, easy to use, and they give results within five minutes. Results can be the difference between life and death because many people who tragically overdose on fentanyl were not aware that they were taking fentanyl.

It is critical that we train our public health professionals on the front lines to carry and facilitate access to this lifesaving tool. The ALERT Act expands an existing SAMHSA program to just do that, provide fentanyl test strips, training, and resources to our nation's first responders, helping them save lives.

I urge everybody to support this bill and I yield back.

*Mr. Griffith. The gentlelady yields back. Is anyone else wishing to speak to the bill?

Seeing none, the question now occurs on forwarding H.R. 1561 to the full committee.

All those in favor, say aye.

All those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

I now call up H.R. 7904 and ask the clerk to report -- 7994. Sorry, the handwriting was -- I read wrong.

*The Clerk. H.R. 7994, a bill to establish a grant program to provide schools with opioid overdose reversal drugs to direct schools receiving Federal funds to report to certain Federal information systems any distribution of an opioid overdose reversal drug, and for other purposes.

*Mr. Griffith. Without objection, the first reading the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone seek to be recognized on the bill?

I recognize the gentleman from California --

*Mr. Ruiz. Yes, sir.

*Mr. Griffith. -- Dr. Ruiz.

*Mr. Ruiz. Thank you, Mr. Chairman. And Diana, thank you so much.

H.R. 7994, the Helping Educators Respond to Overdoses Act, is practical legislation that will save kids' lives. The HERO Act establishes a grant program for schools to purchase opioid overdose reversal drugs, making these lifesaving medications accessible in schools in case, God forbid, a student needs them. It also establishes grants to provide critical training for staff and implement educational resources for students and communities to help combat the opioid epidemic.

According to UCLA health, an average of 22 adolescents ages 14 to 18 died every week in the U.S. in 2022 from drug overdoses, the equivalent of, in some areas, a full high school classroom each week, bringing the death rate to 5.2 per 100,000. This is a public health crisis; we need to take action. And as an emergency medicine physician, I have cared for many patients overdosing on opioids. I have also had to comfort family members of patients who, unfortunately, were not able to receive lifesaving Narcan in time.

Every story that ends in an overdose is tragic, but it cuts that much deeper when it could have been prevented had lifesaving Narcan been available. We need to take action now to mitigate overdoses through training, education, and awareness, and we need to ensure widespread access to opioid overdose reversal medications like naloxone or Narcan. These medications exist, but they only work if they are accessible. That is why I introduced the HERO Act.

I would like to thank the chairman for including this important bill for consideration today, and I urge my colleagues to support and move this bill in a bipartisan manner. We have got to tackle the opioid crisis head on, our kids' lives depend on it. I thank you and I yield back.

*Mr. Griffith. The gentleman yields back. Does anyone else wish to speak on H.R. 7994?

Seeing none, the question now occurs on forwarding H.R. 7994 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

Now we will call up H.R. 9389 and ask the clerk to report.

*The Clerk. H.R. 9389, a bill to amend the Public Health Service Act to authorize funding for nutrition

education and chronic disease prevention at federally qualified health centers, and for other purposes. Be it enacted by the House and the --

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone seek to be recognized on the bill?

I recognize the gentlelady, the vice chair of the subcommittee, Mrs. Harshbarger from Tennessee.

*Mrs. Harshbarger. Thank you, Mr. Chairman. I am proud to speak in support of my legislation, H.R. 9389, the Nutrition Education and Chronic Disease Prevention in Community Health Centers Act.

As a pharmacist for almost 40 years in east Tennessee, I saw firsthand the devastating toll that chronic diseases like diabetes, heart disease, obesity, and hypertension takes on patients, families, and communities. And too often I was filling prescriptions for conditions that might have been prevented, or at least better managed, if patients had received the right education and support earlier. That is especially true in rural America.

Many of the communities I represent face significant health care access challenges, and patients may have to travel long distances to see a specialist. And in many areas the community health center is the most accessible source of primary care. These centers are often the front door to our health care system for working families, rural residents, and underserved populations. Community health centers already provide high-quality, cost-effective care to millions of Americans, but they cannot solve our chronic disease crisis

without the tools and resources to address one of the root causes, which is poor nutrition.

My legislation helps bridge this gap. This legislation would support evidence-based nutrition counseling within community health centers. It would strengthen provider training and nutrition science, encourage team-based care models that include registered dietitians and community health workers, and prioritize centers serving communities with high rates of food insecurity and diet-related disease.

This legislation also builds upon the trusted infrastructure that community health centers already have established in communities across the country. Rather than creating a new Federal program, it strengthens the existing providers that patients already know and trust. This effort aligns with the growing bipartisan recognition that we cannot simply spend more treating chronic disease after it occurs. We must do a better job preventing it in the first place. So every dollar invested in prevention has the potential to save far more in avoidable hospitalizations, emergency room visits, and long-term health care costs. And more importantly, it can help Americans live healthier, longer, and more productive lives.

I have always believed that the best prescription is the one you never have to write or fill. This helps -- this bill helps empower those community health care centers to deliver

that kind of preventive care, and moves toward a health care system that focuses not only on treating illness but on preventing it. And I appreciate the committee's consideration of this legislation, and I urge my colleagues to support its adoption.

And I yield back.

*Mr. Griffith. The gentlelady yields back. Does anyone else wish to discuss -- Ms. DeGette of Colorado.

*Ms. DeGette. Thank you, Mr. Chairman.

As we established in our public hearing -- health hearing earlier this year, nutrition is truly a part of overall health. Nutrition education seamlessly integrates into primary care in particular, complementing routine evaluation and management of chronic conditions. This education could not be more important than for the disproportionately food-insecure population that community health centers serve. These patients don't always live near a grocery store. They may have limited access to affordable, fresh foods, and many rely on food banks to feed themselves and their families.

We heard in April from our community health witness, Dr. Ulmer, about health centers' innovative approaches to connecting patients with healthy food, including food insecurity screenings, medically tailored meals, and on-site food pantry visits. And I have got to say in Denver,

Colorado, my congressional district, we have a number of community health centers, and we have some very innovative food banks in those centers.

There is a drawback of this bill, though, in that it expects more from health centers while failing to provide additional resources. And these health centers are spread awfully thin. I am going to support this bill, but I know that my colleagues will want to work with me to make sure that we properly resource those health centers to be able to provide the health care and the nutrition.

And with that I yield back.

*Mr. Griffith. The gentlelady yields back. Is there any further discussion?

Anyone on this side? Anybody over here?

Seeing no further discussion on the bill, the question now occurs on forwarding H.R. 9389 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

Now I ask the clerk to call up H. 201 [sic].

*The Clerk. H.R. 8201, a bill to amend the Public Health Service Act to require community health centers to provide behavioral and mental health and substance use disorder services, and for other purposes.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Is there anyone who wishes to speak to the bill?

I recognize the gentlelady from Colorado, Ms. DeGette.

*Ms. DeGette. Thank you very much, Mr. Chairman. I really want to commend our colleague, Representative Lee from Nevada, for bringing this bill up, and I want to thank you for putting it on the agenda today.

Low-income adults and people covered by Medicaid are more likely to have behavioral health conditions and more likely to get their health care at community health centers than are high-income adults or those with private insurance. To address this immense need, community health centers have become leaders in integrating behavioral mental health and substance use disorder services into primary care. They provide school-based therapy to students, offer addiction recovery services including medication-assisted treatment, and coordinate care for individuals who need intense case management.

Health centers are increasingly spending more time on these services, but they don't have the resources necessary to meet growing demands. A recent HRSA estimate found that 7.7 million health center patients still need mental health services, and 5.2 million still need substance abuse disorder treatment. And as I mentioned earlier, I see this right in my urban congressional district of Denver, Colorado, where

the community health centers are struggling to provide all these services. By authorizing additional funding this bill will help close that gap and allow health centers to build capacity for comprehensive primary care for all.

I urge support and I yield back.

*Mr. Griffith. The gentlelady yields back. Is there any further discussion?

Seeing no further discussion -- what?

*Ms. DeGette. Wait, Mr. --

*Mr. Griffith. We are moving through like a steam train. All right.

*Ms. DeGette. Keep going.

*Mr. Griffith. All right, we will keep rolling.

The question now occurs on forwarding H.R. 8201 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

I would now ask the clerk to call up H.R. 9393.

*The Clerk. H.R. 9393, a bill to promote price transparency in the health care sector.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I now recognize the gentleman from Kentucky, the chairman of the full committee, for his five minutes on this. Is that right?

*The Chair. I want to speak on the bill.

*Mr. Griffith. Speaking on the bill.

*The Chair. Thank you.

*Mr. Griffith. The gentleman has the floor.

*Mr. Griffith. Thank you, Mr. Chairman.

The committee is considering H.R. 9393, the Lower Costs, More Transparency Act of 2026. I am proud to introduce this legislation with my good friend, Ranking Member Pallone from New Jersey.

The Lower Costs, More Transparency Act builds on years of bipartisan work in this committee and across Congress to codify and build on the Trump Administration's historic price transparency regulations. The legislation requires hospitals and health insurers and other sites of care to be transparent with the costs they charge the American people, with the ultimate goal of equipping consumers and employers with information they need to lower their health care costs.

For years the Energy and Commerce Committee has led the charge on efforts to bring greater transparency to health care. While these efforts did not get over the final finish line last Congress, this subcommittee markup is an important next step in our process to advance these policies. We know

there is more work to do, but it is critical that we keep moving forward and make sure that we get something done on this common-sense issue.

I look forward to working with Ranking Member Pallone, as all of my colleagues on this subcommittee and committee, as we move to get this across the aisle and into the Senate and get this legislation to the President's desk for his signature.

I yield back.

*Mr. Griffith. The gentleman yields back. Now I recognize the ranking member of the full committee, Mr. Pallone of New Jersey, for his five minutes.

*Mr. Pallone. Thank you, Mr. Chairman. I am speaking in support of the bill.

The bill, the Lower Costs, More Transparency Act, brings much-needed transparency to our nation's health system and represents the work that this committee has undertaken for several congresses.

American families are currently facing a health care affordability crisis. Almost 50 percent of Americans report difficulty affording health care. Then more than 40 percent of adults say they have either delayed or forgone medical care because of high costs. Prices for health care services also vary widely, and too often patients are forced to wait until after they receive care and have the medical bill to

fully understand how much they owe.

I think it is unacceptable that some consumers still cannot obtain price information in advance from their provider. What is more, the information can be misleading or inaccurate, making it difficult for consumers to compare prices across health care providers before receiving care. And the lack of transparency into health care prices makes it difficult for consumers to make informed decisions, and it also makes it challenging for employers to negotiate more competitive prices.

So the Lower Costs, More Transparency Act codifies the existing requirements for both hospitals and insurers to make public price information, and strengthens the existing regulatory requirements. The bill improves the accessibility and usability of the price information by requiring hospitals and insurers to display the information in a standardized format. The legislation also strengthens agency enforcement and increases the penalty for hospitals found to be non-compliant. And lastly, the bill requires labs, ambulatory surgical centers, and imaging centers to display their cash prices.

So Americans deserve greater transparency in the prices they pay for health care. The bill will empower consumers and employers with data on the prices hospitals charge and the rates insurers pay so they can compare prices and save

money. I want to say that I hope that we can continue to strengthen this bill and incorporate stakeholders' feedback, as I do believe that we have not had adequate time between our legislative hearing and now to do so.

So I urge my colleagues to join me in supporting H.R. 9393 to bring much-needed transparency to our health system, and I want to thank Chairman Guthrie. Obviously, we worked together on this a long time. Thank you. Thank you, Chairman Griffin.

*Mr. Griffith. Thank you. The gentleman yields back. Is there any further discussion?

*Mr. James. Mr. Chairman?

*Mr. Griffith. I recognize the gentleman from Michigan, Mr. James.

*Mr. James. Thank you. First of all, let me start off by saying I am going to support this transparency package. There is a lot of good stuff in it, but it doesn't go far enough. The ranking member just said he looks forward to strengthening it. Well, I have a great idea. Why don't we go with something we already have? Why don't we go with something that is already bipartisan, already bicameral, and something the ranking member himself put his name to last Congress? Why don't we go with that? Why don't we go with something that not a single person has stood up against on its merits?

Why don't we go with the Patients Deserve Price Tags? It is simple. It requires hospitals to clearly label their prices and make them easy to understand, easy to find, and it is going to allow patients to save money by comparing prices and choosing the lowest-cost options like we do in every other industry across the country for every place in every corner. But we are not doing it here. No. You know why? Because some people don't want to give other people the win in an election year. That is utter bullcrap. And if you think I am full of it, then prove me wrong. Vote for my amendment when I put it up next week.

Patients deserve price tags, not games, not lip service. If you truly intend to give patients what they deserve, American citizens what they have earned, then put your money where your mouth is, Republicans and Democrats.

And so I know the excuses. We didn't have enough time to see what was in the bill. We didn't have enough time to review it. Okay, I am putting everybody on notice right now, both sides. Next week this is going to be an amendment to this process.

And if you are concerned with whose name is on the bill, great. The reason I am putting it on our amendment is to take my name off of it. I am not important; the American people are important. And so if there is any issue with my name being on this bill, then disregard it. I will take it

off. I will put the ranking member's name on it. I will put the chairman's name on it. This is something the chairman supports, something the ranking member helped write, two members of the subcommittee cosponsored. It has bipartisan, bicameral support. This is the type of thing the American people demand and expect. But we are failing in that duty because we are playing games. I am sick of it.

Hospitals want to keep the pricing nebulous so that you can't compare prices. And we are playing along with them in our failure to look past our partisan differences and execute for the American people. My bill, the Patients Deserve Price Tags bill is stronger than the current bill that is currently under consideration. You can compare it on its merits.

And so now you can get the bill, read it. You have my personal cell phone number, the members on this committee. If you don't have time to read it, have your staff reach out to me. I will set up a Zoom, and I will read it to them. It is not that long. I am putting everybody on this committee on notice. This amendment will come up again.

Thank you for listening. I am taking your excuses away, Republicans and Democrats, this is serious. It is for our country. Stop the lip service.

With that I yield.

*Mr. Griffith. The gentleman yields back. Is there any further discussion?

The gentleman from Ohio, Mr. Landsman, is recognized.

*Mr. Landsman. Thank you, Mr. Chair. I have an amendment at the desk.

*Mr. Griffith. An amendment at the desk. The clerk will report.

*Mr. Landsman. Zero ninety-nine.

*The Clerk. Amendment to H.R. 9393 offered by Mr. Landsman of Ohio. Page 3, line 23, insert "from a senior official'' after "attestation.'' Page 24, line 13, insert "from a senior official'' after "attestation.''

*Mr. Griffith. The amendment has been heard.

[The amendment of Mr. Landsman follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. The gentleman from Ohio is recognized to explain his amendment.

*Mr. Landsman. Thank you, Mr. Chair.

This bill is a good bill in terms of us taking some steps to create further price transparency at our hospitals. People, when they go to the hospital, the last thing they need to worry about is not knowing how much each of the things that they are going to be charged for cost. And there have been some attempts to do this in the past, where we have said, look, we want to know what the prices are. You have got to display, make sure that your -- the folks that come to your hospital know how much everything costs. And what has happened is, in many instances, the data is provided but in a way that nobody really understands, you can't really use. And so it is not like when you go to the hospital somebody hands you all of the information in the most usable, digestible, understandable way possible. In fact, it is the opposite.

Often times hospitals will comply with these laws by just providing an Excel spreadsheet. It is super complicated, it doesn't really help us get to what we are trying to achieve here, which is making sure that people know exactly how much everything is that they are being charged, everything. And so -- especially on the front end, before decisions are made.

So the amendment says, look, let's go ahead and pass this bill, but tack on to the bill language that says somebody has to be accountable for ensuring that the data is transparent, that it is accurate, and that we understand it. Somebody has to be accountable, somebody at the hospital, whether that is the CEO, CFO, or somebody at the senior level that is making these decisions. They have to be held accountable. That will make it more likely that what gets provided to folks that go to the hospital is real information, information that will help them determine whether or not they need that procedure or whether or not they can afford what is being offered.

So that is the amendment, and I appreciate the chair and the ranking member, everyone's willingness to continue to work on this. This is hopefully going to come out of the Senate too, and we will have multiple opportunities to improve this. This is one of the changes that I think we should make to ensure that whatever gets passed here gets implemented in a way where people have clear -- a clear understanding as to what is being -- what they are going to get charged for, and that there is total price transparency, and that it is understandable.

So I hope to continue to work with my colleagues on this issue. And while we don't have support for the amendment at the moment, I intend to work with the committee to get to the

point where it is included in whatever gets passed, the House and the Senate. So with that I withdraw my amendment.

Thank you, and I yield back.

*Mr. Griffith. The gentleman yields back. And if I heard correctly, you withdrew the amendment and I appreciate it. We will go from there.

I now recognize -- anybody on this end? I have got to look down here first.

Mr. Carter --

*Mr. Carter of Georgia. Okay.

*Mr. Griffith. -- from Georgia. You are now --

*Mr. Carter of Georgia. Mr. Chairman --

*Mr. Griffith. -- recognized.

*Mr. Carter of Georgia. -- I have an amendment at the desk.

*Mr. Griffith. The gentleman has an amendment at the desk. The clerk will report.

*The Clerk. Amendment to H.R. 9393 offered by Mr. Carter of Georgia. At the end of the bill add the following. Section 7, improving health care coverage under visions plans. A, in general, title 27 of the Public Health Service Act is amended by inserting after section 2719(a) the following new section. Section 2719(b), improving coverage under vision plans. A, in general, with respect to a group health plan or individual or health group insurance coverage

that provides benefits for items and services relating to vision care, the following shall apply. One, duration of limited scope vision plans in the case of a doctor of optometry --

*Mr. Griffith. There will be a waiver of the reading of the amendment.

Without objection, so ordered.

[The amendment of Mr. Carter of Georgia follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. The gentleman from Georgia is recognized to explain his amendment.

*Mr. Carter of Georgia. Thank you, Mr. Chairman. Mr. Chairman, I am proud to offer this amendment alongside Representative Yvette Clarke of New York.

The amendment features two key pieces of legislation -- the DOC Access Act -- that are broadly supported on a bipartisan basis, aimed to boost transparency in the vision benefits market and help lower costs for eye and vision care consumers. Right now the vision benefits market is largely dominated by two vertically integrated vision benefit managers that provide vision insurance coverage to nearly 200 million Americans.

These two VBMs -- notice I said V, as in vision, and not P, as in pharmacy, although it is eerie that these are so similar -- these two VBMs are not only the overwhelming provider of vision benefits in America, but they also manufacture and sell nearly all eyeglass frames and lenses on the market, nearly all of it made in China. They also own thousands of retail optical locations around the country. They own nearly all optical laboratories that produce finished prescription eyewear, and they are aggressively acquiring independent eye care practices nationwide at an astonishing rate.

These two dominant VBMs have successively consolidated

the coverage market, and now they have their sights set on dominating every other aspect of vision care in America.

Did you all catch that? "Sights set on?'' I just want to make sure. Okay.

They use this market dominance to keep prices high, to limit consumer choices, to dictate care, and to force doctors and patients to buy the products they made and use the services they own and operate. Our amendment aims to confront these abuses, and it is time for this committee to act. This amendment is focused on shining a light in preventing VBMs from using their market power to steer patients toward affiliated providers and products. Right now these VBMs force patients to use optical laboratories that are owned or under the direct control of their VBM.

This amendment would prevent VBMs from for mandating use of one of their subsidiary businesses: their optical lab. Patients would still have the choice to use the VBM lab if that is what they wanted, but our amendment would also give them the freedom to choose another lab that worked best for them based on cost, quality, and convenience. Without this fix patients will continue to face higher costs, inferior products and production, and unnecessarily long wait times for a finished pair of prescription eyeglasses.

While we have been working on this issue for years, states like Georgia, New York, Kentucky, New Jersey,

Illinois, Louisiana, Colorado, Texas, and dozens of others are passing tough new laws to address a wide range of VBM abuses. Congress has a responsibility to act, as well, particularly because millions of Americans receive vision coverage through federally-regulated plans that fall outside the reach of many state protections.

Just a few weeks ago the Government Accountability Office released a report requested by Chairman Guthrie that highlighted the extraordinary concentration that exists in the vision benefits marketplace and the challenges it poses for consumers, independent providers, and all of our communities. Consumer advocates and patient organizations are demanding reform. Groups such as Patients Rising and National Consumers League have called for greater scrutiny of VBMs and stronger protections for patients, including those found in our amendment. Their message is clear: patients and consumers deserve transparency, competition, choice, and greater affordability.

We cannot continue to ignore one of the most concentrated and least transparent segments of the health care system. By pulling back the curtain on costly, controlling, and care limiting VBM practices, we can help millions of Americans access more affordable vision care, preserve independent providers, and ensure that patients, not corporate middlemen, remain at the center of important health

care decisions.

Thank you, Mr. Chairman. I look forward to continuing to work with you and my colleagues on both sides of the aisle to advance meaningful VBM reforms, and I yield --

*The Chair. Would the gentleman yield? Would the gentleman yield to --

*Mr. Carter of Georgia. Yes, I would yield to the gentleman --

*The Chair. I just want to say to what -- your discussion, which -- that was my GAO request and report, and I agree with the policy issues we have to address with your bill, with Mr. Landsman's amendment as well, and with Mr. James -- obviously, very passionate about -- as we all are.

And as we do the subcommittee process, the subcommittee markup, full committee markup, as you know, we are running out of legislative days. So we began this bill with the area which we all agree upon which passed this committee, passed the House, and was taken out in the Senate on the Lower Costs, More Transparency. So the opportunities to improve this bill -- that is what the process is -- is from now until we get to the full committee markup, and then beyond as we move forward.

So thanks for everybody offering really good ideas. Thanks for withdrawing your amendments. And we can get to work between now and next -- if it is next week or when we

have our full markup, we will be ready to hopefully incorporate as much of this where it fits and what we can into this bill. So thanks, everybody, for their work.

*Mr. Carter of Georgia. Good.

*The Chair. I yield --

*Mr. Carter of Georgia. I yield back.

*The Chair. -- back to my friend from Georgia.

*Mr. Griffith. The gentleman yields back. Is there any further discussion on the amendment?

*Mr. Carter of Georgia. Mr. Chairman, I am going to pull the amendment.

*Mr. Griffith. The gentleman has been recognized and wishes to withdraw his amendment.

Without objection, so ordered.

Are there any further amendments?

I recognize the gentlelady from Colorado.

*Ms. DeGette. Thank you, Mr. Chairman. I have an amendment at the desk, DeGette_040_XML.

*Mr. Griffith. The clerk will report it.

*The Clerk. Amendment to H.R. 9393 offered by Ms. DeGette of Colorado. Add at the end of section 2 the following new subsection. C, mandatory reporting with respect --

*Mr. Griffith. Waive the reading?

Without objection, waive the reading of the amendment.

[The amendment of Ms. DeGette follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I recognize Ms. DeGette for her five minutes to explain her amendment.

*Ms. DeGette. Thank you so much, Mr. Chairman. It is incredible to me that, of all the bills from our transparency hearing to leave out of this markup, we are not including the ownership transparency legislation that has been championed by our colleagues, Ms. Schakowsky and Mr. Bilirakis, a bipartisan cosponsorship.

All four of our witnesses at the hearing agreed on the importance of this policy. The witness from the Conservative American Enterprise Institute said the persistent challenge of ensuring competitive health care markets "has become more challenging due to recent evolutions in ownership structures and the nature of consolidation.'' Amid the rise of private equity purchasers and both vertical and horizontal consolidation across health care sectors, business structures are becoming more opaque, convoluted, and tough to capture through existing reporting mechanisms.

Addressing this lack of transparency is the absolute bare minimum Congress can do to begin tackling the problem of consolidation, so that is why I am offering an amendment to add ownership transparency to this bill. What the amendment does is simply require reporting of certain health care entities, organizational structures, which I expect will help us understand how different ownership structures underpin

consolidation and drive costs in the system. This amendment will set the table for better understanding just who owns hospitals and practices in our communities, and just how different ownership arrangements affect cost and patient care.

My amendment is substantially identical, with just some technical changes, to the bill that Ms. Schakowsky and Mr. Bilirakis introduced last Congress. Twelve of the Republicans and ten of the Democrats on this subcommittee cosponsored legislation last Congress, the PATIENT Act, that controlled this policy, and I think this is what Chairman Guthrie was just talking about, is some of these things that need to be included in the bill as we move along.

And so I would just ask you, Mr. Chairman, again, will you work with us to address any objections and to work on the drafting so that we can include this policy in our bill as it comes forward in the full committee?

*Mr. Griffith. And I appreciate the gentlelady's question and understand the intent of her amendment and the concept. The markup -- this markup is an important next step in our committee's legislative process to advance these policies. We know there is more work to get some of these policies into a bipartisan place, and we look forward to continuing to work with you ahead of the full committee markup. It is critical that we keep moving forward and make

sure we get something done on this common-sense issue.

*Ms. DeGette. Thank you, Mr. Chairman. Based on those assurances, I will withdraw the amendment.

*Mr. Griffith. The gentlelady withdraws her amendment. Are there any further amendments before the subcommittee?

*Ms. Barragan. I don't have an amendment, but I want to speak on the underlying bill.

*Mr. Griffith. Speaking on the underlying bill, the gentlelady from California is recognized for her five minutes. Ms. Barragan.

*Ms. Barragan. Thank you, Mr. Chairman. I think it is important that we work toward as much transparency as we can get.

We hear Americans tell us over and over again that the cost of health care is too high, and it is only getting more out of control. And when they go to the hospital they often don't know how much a visit or a procedure will cost beforehand, and then they are left with high out-of-pocket costs and even serious medical debt.

Health care is one of the only markets in this country where consumers don't know the price of a service until they receive a bill after the service was provided. This just happened to me. I was sent to GW and showed up. I was told if I paid in advance I would get a discount, and I was given an amount. So I paid that amount. Well, guess what? I went

home and I got a bill. I still got a bill.

And I am not the only one. Lauren in Colorado, she was T-boned by another driver on her way to work so she needed ankle surgery and an overnight stay. She was billed $64,000 by the hospital, and the bill did not clearly explain what services were charged and what was covered by her insurance. In the end the hospital admitted they had prematurely and mistakenly sent Lauren a bill before working out the balance with her insurer. After appealing the denied claims and months of back and forth with both her insurer and the hospital, Lauren only owed a $250 copay.

These are the types of problems Americans face all the time because our health care system is too confusing and consolidated, and not everyone has the time or the knowledge to understand complicated bills and appeal claim denials. Increasing transparency is an important step to help us -- whether that be consumers, employers, or law-makers -- see what is going on behind the scenes and make decisions based on the full picture.

We should require health providers to provide patients a complete explanation of how much their health care costs, including how much the insurer covers and how much the patient is responsible for in a way that is clear and a way that is understandable. Health care providers should be required to provide detailed, itemized bills to patients

before they seek payment and try to collect debt, and providers should be required to publicly post their prices in dollars and cents so that patients aren't blindsided and have more meaningful choice. We need more information on who owns what in the health care system so we can figure out if health insurance plans or health care providers are trying to hide certain business practices to maximize their own profits.

So as we move this bill to full committee, I am glad to hear that more work needs to be done. I urge my colleagues to build on this bill and to make it stronger. We can do that with stronger transparency and accountability so we can get more meaningful information for our constituents.

I ask the committee to add requirements for itemized bills from providers, that they add codifying explanation of benefits that include codes so people know what procedure they had, as well as accountability requirements for middlemen in the health care system.

I know there is work being done on the Senate side on a bipartisan basis that has some good language. So I don't want to get partisan, but at the end of the day this is about consumers, this is about making sure there is strong transparency. Patients and employers deserve clear, accessible information so that they have the power to explore their options and make informed decisions and save money.

And with that I yield back.

*Mr. Griffith. The gentlelady back. Is anyone else wishing to discuss the underlying bill or to make an amendment?

Seeing none, the question now occurs on forwarding H.R. 9393 to the full committee.

All those in favor, say aye.

All opposed, no.

The ayes have it and the bill is agreed to and forwarded to the full committee.

I now call -- would ask the clerk to call up H.R. 9397, and ask the clerk to report.

*The Clerk. H.R. 9397, a bill to amend title 27 of the Public Health Service Act and title 18 of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments, and to direct the Secretary of Health and Human Services to issue guidance on the provision of certain insurance information.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone wish to speak on the bill?

I recognize the gentlelady from Tennessee, the vice chair of the subcommittee, Mrs. Harshbarger, for her five minutes.

*Mrs. Harshbarger. Thank you, Mr. Chairman. Speaking on transparency, I would like to offer my support for H.R. 9397, the Premium Transparency Act, and the legislation is introduced by Congressman Pfluger from Texas.

The Premium Transparency Act will enhance transparency and cost by requiring insurance companies to publicly post the percentage of insurance premiums that go toward health care overhead and profit, and providing this information to consumers will hold insurers accountable for how patients' premium dollars are spent. This will provide another tool for consumers to use as they stop -- as they shop for plans, whether for seniors considering Medicare Advantage plans or in the commercial market.

The bill also requires the Secretary of Health and Human Services 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. Because the most concerning thing for people -- and they would come to me all the time -- you have to triage these because they don't understand all the complicated insurerspeak when they are trying to decide what plan to

purchase. And this will help ensure consumers understand the insurance that they may be enrolling in, and can make the most informed, cost-effective decisions for themselves and their families.

I urge my colleagues to support this legislation advancing from the subcommittee today, and look forward to continuing to work on this legislation ahead of the full committee markup.

And with that I yield back.

*Mr. Griffith. The gentlelady yields back. Is anyone else wishing to discuss the bill?

I recognize the gentlelady from Colorado, Ms. DeGette, for her five minutes.

*Ms. DeGette. This bill requires commercial insurers to disclose how much they spend on patient care versus overhead and profit. Good news. We already passed this when the Democrats passed medical loss ratio standards in the ACA. That is right. This bill's disclosure requirements are already the law of the land. So I am so glad to see my Republican colleagues are finally coming around to some of these provisions in the ACA, and I am happy to support this bill, even though it seems duplicative.

And I yield back.

*Mr. Griffith. The gentlelady yields back. Is anyone else wishing to speak to the bill?

I will recognize myself for five minutes, and I would just say to my friend and colleague from Colorado the intent was great. Unfortunately, some of the companies might be gaming the system by purchasing suppliers of health care, even though they are an insurance company, and then perhaps paying their own suppliers of certain health care more than they pay other suppliers of health care. And so this is a small step, but hopefully at some point we can get it so that everybody can see where all the money is going so we can make sure it does go.

The intent was absolutely right in the original ACA, so I grant you on that one, I give you that point, but I think we have to keep working on it.

*Ms. DeGette. Like I say, welcome to the party, Mr. Chairman.

*Mr. Griffith. Thank you, madam, and I now yield back. And is there anyone else who wishes to get into the fun and discuss the underlying bill?

Seeing none, the question now occurs on forwarding H.R. 9397 to the full committee.

All those in favor, say aye.

All opposed, no.

The ayes have it. The bill is agreed to and forwarded to the full committee.

We will now call up H.R. 9396 and ask the clerk to

report.

*The Clerk. H.R. 9396, a bill to amend title 27 of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require the displaying of claim denial rates.

*Mr. Griffith. And without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I would like to recognize myself, and I would like to offer my support for H.R. 9396, the Prior Authorization Accountability Act. This legislation was introduced by Congressman Goldman from Texas.

The Prior Authorization Accountability Act would require commercial health plans to be transparent with consumers about the prior authorization practices they employ in their plan. The bill would require plans to post information about which items and services are subject to prior authorization, as well as information about the percentage of requests that were approved or denied during a plan year. This information will be posted publicly so consumers know what prior authorization will look like in the plan they may enroll in.

We have heard frustrations with prior authorization practices throughout our affordability hearing series, and this bill will help give consumers the tools they need to navigate the health care market when they are shopping for plans.

Now, that is the script, it sounds really good. And let me -- but I want to explain it in more common language, if I might. What this means is when you go to renew your insurance next year or your plan, you can see if your plan is doing a whole lot of pre-authorizations and denying a large number. And with that information you can see if plan A is denying 60 percent of the pre-authorizations and plan B is

only denying 10 percent. You might want to get plan B. You might want to spend a dollar or two extra. It might be a little bit cheaper, but you are more likely to get better health care.

So this is just to help the consumers figure it out. It is not that complicated of a bill, but it is a good bill, and I urge my colleagues to support this legislation advancing from the subcommittee today and look forward to continuing to work on this legislation ahead of the full committee markup.

With that I yield back and recognize the gentlelady from Colorado, Ms. DeGette, the ranking member of this -- the ranking member of this subcommittee, for her five minutes on the issue.

*Ms. DeGette. Thank you, Mr. Chairman. You are exactly right. Insurers use prior authorization to reduce their likelihood of paying for unnecessary medical expenses. But along the way what they do is they delay or even deny patients' essential care, and they bury providers under the burdensome administrative back and forth.

All of us have calls every week in our congressional offices from our constituents who are in limbo while they need essential health care services from the prior authorization, and it is shameful. To address this issue policy-makers, researchers, and patients alike need to have a clear view of the problem.

This bill requires insurers to display certain prior authorization information, including the rate of denials, the rate of those denials successfully appealed, and the average amount of time required per prior authorization determination. They say sunlight is the best disinfectant, so public disclosure of this information may force bad actors to stop some of the most abusive prior authorization practices. It is a small step, as you said, but it is an important step, and it is legislation that individuals can use to actually make more informed choices.

I urge everybody to support this bill, and I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize the gentlelady of Iowa, Dr. Miller-Meeks, for her five minutes regarding this bill.

*Mrs. Miller-Meeks. Thank you, Mr. Chair. People may wonder why would a consumer or patient even bother to look at prior authorization, the number of times it is utilized and the number of denial claims. So I am going to give you a real-world example of that.

As an ophthalmologist in a small town in rural Iowa, I had a 13-year-old boy referred to me from a rock that hit him in his eye coming from a lawn mower. He was driven into the clinic by his parents. He had an open globe, meaning a corneal laceration which needed to get repaired, and we then spent the next several hours trying to get prior

authorization from his insurance company in order to repair his open globe. The child may easily have lost his eye and lost his vision.

Now, if that is important to you as a parent, if that is important to you as a patient, then you want to know if your insurance company is systematically using prior authorization to delay care or to deny care. And if they are using denial of claims to deny care -- if you are wondering why you haven't gotten your bill from your doctor's office, often it is because it has gone to the insurance company, they have denied the claim, then your provider has to go through this arduous process of trying to prove that the claim was valid before it is finally paid off and you finally get a bill for your minimal co-pay.

I urge all of my colleagues to support this bill. Let's get it across the finish line. I could not agree with the chair or Ranking Member DeGette more: sunshine is the best medicine.

Thank you, I yield back.

*Mr. Griffith. The gentlelady yields back. Does anyone else wish to be recognized to discuss the bill?

Seeing none, the question now occurs on forwarding H.R. 9396 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it, and the bill is forwarded to the full committee.

I now call up H.R. 9390 and ask the clerk to report.

*The Clerk. H.R. 9390, to amend title 27 of the Public Health Service Act to require certain facilities to post prices on the walls. Be it enacted by the Senate and House of Representatives of the United States of America and Congress assembled --

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And now recognize the gentlelady from Iowa, Mrs. Miller-Meeks, to explain the bill.

*Mrs. Miller-Meeks. Thank you very much, Mr. Chair. I move to strike the last word on my bill, H.R. 9390, the Prices on the Wall Act of 2026.

As a physician I have spent my career helping patients navigate a health care system that is too often confusing, frustrating, and far too expensive. One of the biggest challenges patients face is not knowing what something will cost until weeks or even months after receiving care. Imagine walking into a grocery store, a hardware store, or a restaurant and finding that none of the prices are listed. You would never know what you are expected to pay until after you left. Yet that is exactly how the health care system often works. That is why I am proud to introduce the Prices on the Wall Act of 2026.

My legislation takes a simple, common-sense step towards greater transparency. Beginning in 2028, hospitals, ambulatory surgery centers, laboratories, and imaging providers would be required to post the prices of commonly shoppable health care services in visible locations where patients can easily see them before receiving care. The bill requires facilities to display their discounted cash prices or, when those are unavailable, often readily understandable price information directly on their walls for patients to

review.

For years policy-makers on both sides of the aisle have supported efforts to increase health care transparency. My bill builds on those efforts by making price information more visible and accessible to the people who need it most. Health care consumers deserve the same transparency that exists in virtually every other sector of our economy. Price transparency empowers patients, it encourages competition, it rewards providers who deliver the highest quality care at the most affordable cost, and it helps families make informed decisions about where they seek care.

This is not about increasing bureaucracy; it is about providing patients with clear information; it is about respecting consumers and bringing greater accountability to our health care system. Americans work hard for every dollar they earn, and they deserve to know what price they are paying before they receive a service. Transparency is not a partisan issue; it is a patient issue, and I have put that into effect in my practice so it is doable.

I urge my colleagues to support the Prices on the Wall Act, and I yield back. Thank you, Mr. Chair.

*Mr. Griffith. The gentlelady yields back. Is anyone else wishing to discuss the bill?

I recognize the gentleman from New Jersey, Mr. Pallone, the ranking member of the full committee, for five minutes.

*Mr. Pallone. Thank you, Mr. Chairman. I am opposed to the bill. And while I support efforts to bring transparency to our nation's health system, this bill does not strengthen transparency or address the health care affordability crisis created by President Trump and congressional Republicans, in my opinion. On the contrary, I am concerned that the bill will cause more confusion for consumers and deter them from seeking care.

And don't get me wrong, the intent of this bill is a good one, to bring more transparency, but I am concerned that this is just going to create more confusion because the prices that will be posted on the wall are not actually the prices that most patients would actually pay for those services. The bill says that all hospitals, ambulatory surgical centers, labs, and imaging centers have to post cash prices for health care services that can be scheduled in advance, and this includes hundreds and possibly thousands of procedure codes that providers would be required to post on the wall, right?

Now, hospitals are required to publish their price information online, including for shoppable services, but requiring hospitals to post cash prices on their walls for various procedure codes would likely only confuse patients and deter insured individuals from seeking care. So patients who need care will also have to determine which procedure and

billing codes that are ancillary will be furnished as part of the service.

So I just think that the bill creates, you know, sort of a false sense of transparency that will make it even more difficult for consumers who are already struggling to navigate and understand the costs of a health care procedure. I don't see how it helps, but I know you are well intentioned, but I would urge a no vote on the bill.

*Mr. Griffith. And the gentleman yields back. Is there further discussion on the bill?

Seeing none, the question now occurs on forwarding H.R. 9390 to the full committee.

All those in favor, say aye.

All those opposed, no.

The ayes have it, and the bill is agreed to and forwarded to the full committee.

I now call up H.R. 3514 and ask the clerk to report.

*The Clerk. H.R. 3514, to amend title 18 of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone seek to be recognized on the bill?

The gentleman from Pennsylvania, Dr. Joyce, is recognized to speak to the bill.

*Mr. Joyce. Thank you, Mr. Chairman. I wish to add my own support to H.R. 3514, the Improving Seniors' Timely Access to Care Act, and urge the swift passage of this crucial bipartisan legislation by our committee.

I would also like to directly thank you and Chairman Guthrie, Ranking Members Pallone and DeGette for bringing this bill to us today.

This bill represents truly a bipartisan product that is currently supported by over 290 House cosponsors and has the endorsement of hundreds of patient, physician, and health plan advocacy organizations. The seniors act will make critical improvements to the prior authorization process in the Medicare Advantage program, reducing administrative barriers that will ultimately deliver faster and more complete care to patients.

Specifically, this bill requires MA plans to adopt standardized electronic prior authorization systems to expedite the processing of requests. This will improve transparency around the utilization of prior auth in MA. It clarifies HHS authority to set timeliness for determination and finally mandates long-overdue oversight into the prior

authorization process.

This represents a consensus common-sense fix to one of the glaring issues facing providers and patients today. I urge all of my colleagues to support this legislation.

And I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize the gentlelady from Washington, Dr. Schrier, for five minutes to discuss the bill.

*Ms. Schrier. Thank you, Mr. Chairman. I am so happy that this committee is moving the long-overdue bipartisan legislation, the Improving Seniors' Timely Access to Care Act.

This is a big deal. I hear from my constituents all the time that the health insurance that they have is not holding up its end of the bargain. Insurance companies are delaying or denying care due to really abusive requirements for prior authorizations where there should not be that requirement.

By the way, I hear the same frustration from doctors and from hospitals. They are forced to hire more staff just to process prior authorization requests than nurses. The most egregious offender in all of this is Medicare Advantage, which is a type of Medicare plan that contracts with private insurance companies to deliver care. And more than half of seniors are enrolled in Medicare Advantage plans because they are often more affordable, and they seem great until a

patient gets sick and can't get the treatment that their doctor recommends because of abuse of a prior authorization requirement.

In 2024 traditional Medicare beneficiaries saw around 625,000 prior authorization requests. Now here is a contrast: in that same year Medicare Advantage beneficiaries saw over 50 million prior authorization requests. And I want you to keep in mind that enrollment in these programs is about 50/50, so this is really disproportionate.

This bill is an important step toward doing the right thing for seniors by requiring Medicare Advantage plans to adopt an electronic prior authorization system and to improve transparency around Medicare Advantage prior authorization use and potential abuse. I urge my colleagues to vote for this bill, and once we pass it into law I look forward to working with the committee to pass even more prior authorization reforms that put the doctor and the patient, and not the insurance company, back in charge of clinical decision-making.

Thank you. I yield back.

*Mr. Griffith. The gentlelady yields back. Does anyone else wish to discuss the measure?

I recognize the gentlelady from Iowa, Dr. Miller-Meeks, for her five minutes to discuss the bill.

*Mrs. Miller-Meeks. Thank you, Mr. Chair. I move to

strike the last word. I rise in support of H.R. 3514, the Improving Seniors' Timely Access to Care Act of 2025.

As a proud original cosponsor of this bipartisan legislation and as a physician, I have seen firsthand the frustration patients experience when administrative delays stand between them and the care they need. While prior authorization can be an important tool to ensure appropriate care and manage costs, the current process is too often outdated, burdensome, and unnecessarily time-consuming for both patients and especially providers.

This bill takes a common-sense approach to modernizing prior authorization within seniors' health insurance Advantage plans. It streamlines the process through electronic prior authorization, improves transparency, establishes clear timelines for decisions, and increases accountability so patients and providers have greater certainty when seeking medically necessary care.

Let me give you an example of medically necessary care. I saw a patient with very -- symptoms that were very subtle, no signs, and I suspected that the patient had a base-of-the-brain brain tumor. A CT scan will not diagnose a base-of-the-brain brain tumor because the bone gets in the way. Through prior authorization, multiple hours by my staff, multiple hours on the phone by myself, they would not approve an MRI which was what we requested.

They finally approved months later a CT scan. Then it is scheduled and it takes a couple of weeks. Then you get the results. And guess what? The CT scan didn't show anything. So the next test you have to order is now an MRI. We finally got the authorization from the MRI. We finally got the MRI. And guess what the MRI showed? Lo and behold, even though the patient had no signs and very few symptoms, the MRI showed a base-of-the-brain brain tumor. Now, six months of delay for this patient could have been life-threatening. This is an important issue that should have, as Dr. Schrier and Dr. Joyce said, already been addressed.

So for seniors this means fewer delays and faster access to treatment, and sometimes lifesaving treatment. For physicians and other providers this means less time spent on paperwork and more time spent on actually caring for patients, which is what we prefer to do. And for rural providers, including many in my district in Iowa, it means reducing administrative burdens that can be especially challenging for smaller practices with limited staff and resources. Importantly, this bill does not eliminate prior authorization. Rather, it improves the process so it works more effectively for patients, for providers, and health plans alike.

This legislation has earned broad bipartisan support because it addresses a problem everyone recognizes while

preserving the benefits of appropriate utilization management. I thank the chairman, ranking member, and my colleagues for their work on this legislation, and I urge support for improving seniors' timely access to care.

I yield back.

*Mr. Griffith. The gentlelady yields back. I now recognize gentlelady from Texas, Mrs. Fletcher, for her five minutes to discuss the bill.

*Mrs. Fletcher. Thank you so much, Mr. Chairman, and I just want to join with my colleagues on both sides of the aisle who are speaking up in support of this bill. I will keep it brief, but I appreciate all the physicians who have weighed in.

And while I am not a physician, I represent a whole lot of them who work at the Texas Medical Center and throughout my district, and one of the things I have heard about from them, as well as from their patients, is the problem with prior authorizations. They just tell me consistently that it slows down access to appropriate care, forcing the physicians, their staff, the patients -- everybody is on the phone, calling insurance companies trying to get approval for the care that their physicians think that they need. It is totally wasted time, worse health outcomes.

And one of the things that I am also hearing it is really contributing to is the high rate of burnout. We are

trying to get more people access to more care and you are wasting doctors' time, patients' time, staff time, and you are seeing physicians retiring earlier. We are already talking in this committee about a workforce shortage. We need to do things that make it easier for them to practice and easier for their patients to get the care that they need. And certainly, as Dr. Schrier mentioned, it is really clear that prior authorization needs to be reformed generally. And I hope that, in addition to this, we will be taking on more prior authorization legislation.

But it is particularly acute in Medicare Advantage plans, and so many seniors are relying on Medicare Advantage for health care and I think we have all seen the challenges that they face in just trying to get the care they need. So that is why I am really glad that the committee is considering this bill today. This is why I, of course, am a cosponsor of the bill. It really is a critical step in reforming the current prior authorization requirements in Medicare Advantage and ensuring that seniors have access to quality health care.

So I hope this alleviates some of those burdens. And I -- again, like Dr. Schrier, I hope this is the first of many things we can do to help address this problem.

And with that I thank you and yield back.

*Mr. Griffith. The gentlelady yields back. Is anyone

else wishing to discuss the bill?

Mr. Carter of Louisiana is recognized for his five minutes to discuss the bill.

*Mr. Carter of Louisiana. I move to strike the last word.

*Mr. Griffith. The gentleman is recognized.

*Mr. Carter of Louisiana. As a proud sponsor of H.R. 3514, the Improving Seniors' Timely Access to Care Act of 2025, I am pleased to speak in support of this bipartisan legislation led by Representatives DelBene and Kelly.

Louisiana's -- Louisiana State has one of the highest percentages of MA enrollees in the country, many of whom live in my district. That is why ensuring seniors can access high-quality care without unnecessary delays in prior authorizations for me and my constituents is essential. The Improving Seniors' Timely Access to Care Act of 2025 would take steps to strengthen the Medicare Advantage program and improve the experience of seniors who rely on it in states like mine.

More specifically, the bill would increase transparency, streamline the prior authorization process, and expand protection for enrollees. These reforms would also help to reduce administrative burden on physicians and allow for more time to be spent with patients.

I support my colleagues' bipartisan effort to improve

the Medicare Advantage program for seniors, and encourage my colleagues to join me in voting for this bill that will end the frustration for individuals who wait for their medication to be filled, only to be told by their pharmacy that they are waiting for another prior authorization.

While people often times go without their medicine for days, weeks waiting for a prior authorization, at what point do we get our arms around this? And I am hopeful that this will be the step that we so desperately need to get relief to the patients and caregivers who deserve it.

With that I yield.

*Mr. Griffith. The gentleman yields back. Is anyone else wishing to discuss the bill, H.R. 3514?

Seeing none, the question now occurs on forwarding H.R. 3514 to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it and the bill is agreed to and forwarded to the full committee.

The clerk will now call up H.R. 9392.

*The Clerk. H.R. 9392, to amend title 18 of the Social Security Act to require the inclusion of certain information in Medicare Advantage encounter data. Be it --

*Mr. Griffith. And without objection, the first reading of the bill is dispensed with, and the bill will be open for

amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I recognize Dr. Joyce speaking to the bill.

*Mr. Joyce. Thank you, Mr. Chairman. I indeed wish to speak in support of H.R. 9392, the Medicare Advantage Cost Transparency Act, and thank Ranking Member DeGette for partnering on this important bipartisan piece of legislation.

This bill represents an important step in the right direction in improving encounter data submissions made by Medicare Advantage plans to ensure that they account for the total allowable cost for items and services and include the amount of cost sharing imposed on the beneficiary for such services. This higher level of transparency will help inform both the patient and the policy-makers as we further evaluate the MA program with more objective data.

This legislation will also provide for us important insight into the at-home health risk assessment services, and actually who is furnishing those. While this bill represents a critical step towards greater transparency in the MA program, there is still work that needs to be done to ensure that this legislation accounts fully for the innovative plan designs that include value-based contracting in the allowed amounts to ensure that we are truly capturing the entire picture.

I am also committed to ensuring that this legislation is building in a clear, uniform standard so that the data is

genuinely comparable across plan types, and we don't distort the very transparency that we are working to create.

I look forward to working with Ranking Member DeGette, urge that this subcommittee advance this bill today, and continue working this bill in a bipartisan manner between now and the full committee.

I yield back.

*Mr. Griffith. The gentleman yields back. I now recognize the ranking member of the subcommittee, the gentlelady from Colorado, Ms. DeGette, to discuss her very good bipartisan bill.

*Ms. DeGette. Thank you. Thank you, Mr. Chairman, and thank you to my friend, Mr. Joyce, for working on this bill with me.

Back when I was the chair of the Oversight and Investigation Subcommittee and you, Mr. Chairman, were the ranking member of that committee, we held a hearing on Medicare Advantage with the GAO, OIG, and MedPAC, and the message from the watchdog agencies was loud and clear: we needed complete, accurate, valid encounter data if we want Medicare Advantage to succeed.

This bill takes -- seeks to take another step in doing that, giving policy-makers, the Federal Government, and researchers the cost information we need to have while we find out what Medicare Advantage plans are paying for care

and what patients themselves are paying out of pocket.

The program is an important option for our seniors, but all of us are deeply concerned by evidence that patients are not getting the care they need and that these private insurance companies are gaming the system to profit from taxpayer dollars. That is why the bill also requires a particular look at the practice of home health risk assessments which insurers use to code patients as sick, receive greater compensation from the government, and not actually contact -- or connect seniors to care. The information will help us protect our seniors enrolled in Medicare Advantage, which is 35 million and growing, and the long-term viability of the Medicare program.

I hope that our colleagues will all join Dr. Joyce and me on this effort and vote in favor of the bill, and I yield back.

*Mr. Griffith. The gentlelady yields back. Does anyone else wish to discuss the bill?

Seeing none, the question now occurs on forwarding H.R. 9392 to the full committee.

All those in favor, say aye.

Those opposed, no.

The aye has it, and the bill is agreed to and forwarded to the full committee.

I now call up H.R. 5243 and ask the clerk to report.

*The Clerk. H.R. 5243, a bill to amend title 18 of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage.

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point.

Seeing no objection, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. Does anyone seek to be recognized on the bill?

I recognize the gentlelady from Colorado, Ms. DeGette, to speak to H.R. 5243.

*Ms. DeGette. Mr. Chairman, Medicare Advantage plans often woo seniors with enticing supplemental benefits that traditional Medicare just doesn't offer. But beneficiaries often find when they are enrolled these supplemental benefits are beyond -- are behind barriers to redeeming them, or seniors simply don't utilize the full range of supplemental benefits available to them.

In addition to under-utilization concerns, supplemental benefits have been added to the Medicare program without a real policy debate about how they are financed and whether they are meaningfully improving seniors' health. This bill would require Medicare Advantage plans to disclose exactly which supplemental benefits they offer, how seniors are utilizing them, and how much they cost. That way policy-makers have a clear view of supplemental benefits to ensure both success of Medicare Advantage and long-term viability of the larger medical -- Medicare program.

I would like to commend our colleague from the full committee, Representative McClellan, for her great work in developing this bill.

And I yield back.

*Mr. Griffith. The gentlelady yields back. Is there any further discussion?

I recognize the gentlelady from Washington, Dr. Schrier. The gentlelady is recognized for five minutes.

*Ms. Schrier. Thank you, Mr. Chairman.

We have all seen the marketing for Medicare Advantage plans: free gym memberships and free golf clubs and zero premiums. It is quite the sales pitch. And as I have mentioned before, these plans sound great until you actually have a health challenge and then you face a mountain of prior authorization requirements to get the care you need.

But supplemental benefits are one of the big driving factors behind increasing enrollment in Medicare Advantage plans. These benefits range greatly, but can include everything from vision, hearing and dental, to gym memberships and more, and these are really nice benefits and it makes sense that seniors factor them into their enrollment decisions. But it is really hard to measure the value of these benefits when we don't have reliable data on how much seniors are actually using them and what they cost.

As policy-makers we need this data so we can improve Medicare Advantage plans and ensure that they are actually delivering the benefits and care that seniors deserve. It is also a great way for us to consider whether other things would be better, more effective supplemental benefits like

medically-tailored meals.

I want to express support for this important bill that will finally give Congress more insight into the utilization of supplemental benefits provided by Medicare Advantage plans. It is a thoughtful and important step toward reform, and I encourage my colleagues to vote yes.

I yield back.

*Mr. Griffith. The gentlelady yields back. Is anyone else wishing to discuss H.R. 5243?

*Mr. Pallone. I have an ANS.

*Mr. Griffith. There is an amendment. Representative Pallone of New Jersey.

*Mr. Pallone. Mr. Chairman, I have an amendment at the desk labeled amendment in the nature of a substitute to amend title 18 of the Social Security Act.

*Mr. Griffith. Would the clerk call it up, please?

*The Clerk. Amendment in the nature of a substitute to H.R. 5243.

*Mr. Griffith. Waive the reading. Without objection, waive the reading of the amendment.

[The amendment of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. I recognize the gentleman from New Jersey for five minutes to discuss or explain his amendment.

*Mr. Pallone. Thank you, Mr. Chairman. My amendment makes technical and conforming changes based on technical assistance to H.R. 5243.

The bill, led by Representative McClellan, would require Medicare Advantage insurance companies to report data on supplemental benefits.

Medicare provides health coverage for over 64 million beneficiaries and is the single largest payer of health coverage in the U.S., and more than half of all Medicare beneficiaries are now enrolled in an MA plan. Medicare spending is expected to double over the next 10 years, with payments to MA insurance companies totaling over $9 trillion. And while the MA program offers seniors flexibility in the way they receive their medical care, it is important that we ensure Medicare remains financially viable and that seniors are receiving the high-quality care they deserve.

Now, the Medicare Payment Advisory Commission has consistently found that providing care under the MA program has cost more than under traditional Medicare. In 2026 payments to MA plans were expected to be 14 percent more per beneficiary, totaling $76 billion in overpayments to insurance companies. If this trend continues, it will translate to $1.2 trillion in overpayments to MA insurance

companies over the next 10 years.

And despite the large costs associated with the MA program, there is limited data to conduct oversight and ensure that the program is providing good value for our Federal dollars. The Federal Government is expected to spend over $1 trillion over the next decade on MA supplemental benefits alone, yet there is limited data about the scope of supplemental benefits offered. In particular, there has been no meaningful accounting about whether or not seniors are actually using supplemental benefits and if their usage correlates to the additional money insurance companies are being paid. There is also very limited data about how MA plan cost-sharing reductions affect enrollees.

So due to the incomplete and limited data, it is challenging to determine the value of supplemental benefits to seniors and to taxpayers. As Medicare payments for supplemental benefits continue to increase, we must better understand if they are helping seniors and whether they are being delivered at a reasonable cost.

I am also concerned that all Medicare beneficiaries are having to pay higher premiums to pay for these supplemental benefits, though not all have access to these services.

So this bill, H.R. 5243, would require plans to report on enrollee-level data on supplemental benefits and will provide important data to regulators and policy-makers to

help us conduct oversight and assess the program performance. I would urge members to support the ANS and -- as well as the underlying bill.

And with that, Mr. Chairman, I yield back.

*Mr. Griffith. The gentleman yields back. Is there any further discussion of the amendment in the nature of a substitute?

Seeing none, the vote occurs on the amendment.

All those in favor of the amendment in the nature of substitute offered by the gentleman from New Jersey shall signify by saying aye.

All those opposed, nay.

The ayes have it. The amendment in the nature of a substitute is agreed to.

Is there any further discussion on the underlying bill?

The question now occurs on forwarding H.R. 5243, as amended, to the full committee.

All those in favor, say aye.

Those opposed, no.

The ayes have it. The bill is agreed to and forwarded to the full committee.

And now we bring up 9395, the final bill of the day.

Mr. Clerk?

*The Clerk. H.R. 9395, to amend title 18 of the Social Security Act to require certain reporting with respect to

agents and brokers of Medicare Advantage organizations. Be it --

*Mr. Griffith. Without objection, the first reading of the bill is dispensed with, and the bill will be open for amendment at any point. Any objections?

Seeing none, so ordered.

[The bill follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I will now recognize the gentlelady from New York, Ms. Ocasio-Cortez, to explain her bill.

*Ms. Ocasio-Cortez. Thank you, Mr. Chairman, and I would like to thank the chairman and ranking member for including my bill, the Transparency in Medicare Advantage Steering Act, in today's markup.

I have spoken about Medicare Advantage many times in this committee, and I believe we need wholesale reform of the program. But my bill before the committee today addresses one aspect of Medicare Advantage that needs reform, and that is with our agent and broker system. As many know, Medicare Advantage is not traditional Medicare. It is private health insurance run by for-profit health insurance companies. And those health insurers make more money if they have more people enrolled in their particular MA plan, and that is where agents and brokers come in. Health insurers pay agents and brokers to steer people towards their MA plans. And in other words, these brokers are financially incentivized to enroll individuals in specific plans.

Even though Medicare Advantage is private, for-profit insurance, it is funded by public dollars. And that means this is all done with taxpayer dollars. And we are talking about billions. According to a study conducted by Brown University, agents and brokers reportedly received $10 billion from Medicare Advantage insurers for enrolling people

into specific programs in 2022, and many researchers who conducted this study believe that this $10 billion figure is likely an under-estimation.

My bill would address this lack of transparency. It would require for-profit health insurers with Medicare Advantage plans to report on whether their members used an agent or broker to enroll in one of their plans, the amount of compensation health insurers provided to those brokers, and the type of compensation they provided so we know if agents and brokers are receiving a free vacation or a bonus for enrolling someone in one plan over another. My legislation would make all of this information publicly available.

While there were other portions of the bill that were not included in the markup, they were discussed at the legislative hearing two weeks ago. And the full bill includes a provision to limit the compensation provided to agents and brokers and redefine what is even considered compensation. Nevertheless, I look forward to moving this critical transparency piece forward so we can collect the information we need to enact greater reform to the Medicare Advantage program.

I urge my colleagues to support this legislation, and I yield back. Thank you.

*Mr. Griffith. The gentlelady yields back. Is there

any further discussion on the underlying bill, H.R. 9395?

I recognize the gentlelady from Washington, Dr. Schrier, for her five minutes to discuss the bill.

*Ms. Schrier. Thank you, Mr. Chairman. I am really glad this committee is moving important legislation to provide much-needed transparency when it comes to the broker and agent system that is influential in steering seniors towards certain Medicare plans.

I just want to start by saying Medicare is really hard to navigate, and choosing any insurance is challenging. So seniors absolutely need assistance and guidance when finding the right plan for them. But that assistance should be independent, and unbiased, and guided by what helps the seniors most. The current system, though, prioritizes sales volume over beneficiaries, and we know insurance companies are steering seniors into their own Medicare Advantage plans rather than helping patients find the best plan for their own health needs.

Brokers and agents receive higher commissions when they enroll seniors in Medicare Advantage plans compared to traditional Medicare. However, when studies have asked those same brokers and agents what plans they would personally choose, many of them say they favor traditional Medicare plans with a Medigap supplemental policy over Medicare Advantage. That really says everything you need to know.

We need to align financial incentives with what is in the beneficiary's best interests. Financial advisors have a fiduciary responsibility, and those that guide seniors in choosing a Medicare plan should have that same responsibility. And we have a proven model that works: the federally-funded ACA navigator program that helps beneficiaries enroll in ACA health plans, the one that works for them. And there are no kickbacks.

I am proud to support this legislation which would require insurance companies to provide transparency around broker compensation, and I encourage my colleagues to vote yes.

I yield back.

*Mr. Griffith. The gentlelady yields back. Is there any further discussion on H.R. 9395?

Seeing none, the question now occurs on forwarding H.R. 9395 to the full committee.

All those in favor, say aye.

All opposed, no.

The ayes have it. The bill is agreed to and forwarded to the full committee.

Without objection, staff is authorized to make technical and conforming changes to the legislation approved by the committee today.

Seeing no objection, so ordered.

The committee stands adjourned.

[Whereupon, at 3:24 p.m., the subcommittee was adjourned.]