



March 26, 2026

Legislative Update: Summary of the Patients Deserve Price Tags Act

Overview

This month, the Patients Deserve Price Tags Act ([S. 2355/H.R. 5582](#)) was featured in a Senate Health, Education, Labor, and Pensions (HELP) Committee [‘Member Day’](#) hearing. The bill, introduced last year, would expand existing federal reporting requirements for hospitals, providers, and health insurers, provide consumers with clear, concise information on the costs of health care items and services, and increase data accessibility for plan sponsors. This bill aligns with other legislative efforts to increase transparency into health care business practices, such as the Consolidated Appropriations Act, 2026 ([H.R. 7148](#)), which implemented annual reporting and transparency requirements for plans and pharmacy benefit managers operating government and commercial plans. Comments made during [recent House and Senate committee hearings](#) on health care affordability echo a growing desire among federal policymakers to make health care costs more transparent. The following summary outlines each section of the bill.

Sec. 2 – Strengthening Hospital Transparency Price Transparency Requirements

Current law requires hospitals to compile annual public reports on standard charges for items and services provided, in accordance [with guidance developed by HHS](#). The Patients Deserve Price Tags Act codifies these regulations and would statutorily require hospitals to compile and disclose a monthly list of standard charges, made freely and easily accessible to the public, in a uniform method and format to be determined by HHS. Until Dec. 31, 2026, these lists must include at least 300 shoppable items and services provided by the hospital and specified by CMS, after which it must include all shoppable items and services offered. Hospitals must also list the CMS-specified shoppable services they do not provide. In the context of this bill, the “standard charges” that must be listed in the report refer to:

1. A plain language description of each item/service, plus applicable nationally recognized billing codes,
2. The gross charge per service,
3. The discounted cash price, or the minimum cash price accepted from self-pay patients if no discount exists, as well as a link to the hospital’s charity care policy. Such prices must be accepted by as payment in full when made from any cash-paying patient, regardless of their insurance coverage,
4. Payer-specific negotiated charges, attributed with the name of each third party payer and plan tied to such charges. If payer-specific charges are generated by an algorithm, percentage of another amount, or formula, hospitals must also disclose the relevant algorithm, percentage, formula, or other applicable contract terms,
5. De-identified maximum and minimum negotiated charges, and

6. Any additional information determined necessary by HHS to inform consumers of standard hospital charges and prices.

HHS is required to establish a uniform reporting method and format for hospitals to use for publicizing standard charges for items and services. All standard charge information must be made compiled in machine-readable spreadsheet format, meet HHS accessibility and usability standards, and be updated in consultation with stakeholders. A hospital's use of a price estimator tool would not be considered compliant with this section. HHS and the HHS Inspector General must establish a process to annually monitor hospital industry compliance with this section, while a hospital's representative (a C-suite or executive of equivalent seniority) is required to attest to the accuracy of disclosures made under this section.

This section grants HHS the authority to notify hospitals with a request for a corrective action plan within 30 days of determining noncompliance; issue daily civil monetary penalties, scaled to a hospital's size and length of noncompliance, within 45 days of submitting the request for corrective action; increase penalties through the rulemaking process starting in 2027; and impose penalties of \$500,000 up to \$10,000,000 on hospitals that are willfully noncompliant two or more times in one year. HHS will not grant waivers, delays, or other mitigations of civil monetary penalties to violating entities. Sec. 2 also includes various definitions, as well as a provision allowing for existing state transparency laws to remain applicable unless they conflict with the implementation of this section.

- Effective Jan. 1, 2026. The requirement for HHS to develop uniform methods and formats by Jan. 1, 2026 will need to be amended to a later date.

Sec. 3 through Sec. 5 – Increasing Price Transparency of Clinical Diagnostic Laboratory Tests, Imaging Services, and Ambulatory Surgical Centers

Sec. 3, Sec. 4, and Sec. 5 amend the Public Health Service Act (PHSA) by extending increased price reporting and transparency requirements to clinical diagnostic laboratories, imaging services, and ambulatory surgical centers. It includes similar requirements for these entities to make public, monthly disclosures of pricing information. As with Sec. 2, this information must include plain language description of services provided, gross charges, discounted cash prices, de-identified maximum and minimum negotiated prices, and other relevant information deemed necessary to improve consumer understanding. These sections also require disclosure of payer-specific negotiated rates, clearly linked to each third party payer and plan, along with algorithms, percentages, or related contract terms used by payers in price negotiations.

HHS is again required to establish uniform reporting methods and formats based on machine-readable spreadsheets. HHS is granted enforcement authority, with the power to grant civil monetary penalties to noncompliant entities. Civil monetary penalties may not exceed \$300 per day for laboratories, imaging services, and ambulatory surgical centers.

- Effective July 1, 2027, HHS to promulgate guidance on uniform reporting methods and formats by Jan. 1, 2027.

Sec. 6 – Strengthening Health Coverage Transparency Requirements

Sec. 6 codifies the Transparency in Coverage rules promulgated in accordance with the Affordable Care Act, increasing price transparency requirements for insurers and group health plans. Exchange plans are required to disclose specified pricing information to consumers on items and services through an online price tool or a paper or phone disclosure. Specified pricing information includes:

1. In-network rates for participating providers,
2. Maximum allowed costs for out-of-network providers,
3. Expected cost sharing rates, including deductibles, copayments, and coinsurance,
4. The amount a beneficiary has already accumulated towards one's deductible or out-of-pocket maximum,
5. The amount a beneficiary has accumulated towards a frequency or volume limitation, if a plan offers such limitations,
6. Any prior authorization, step therapy, fail first, or similar utilization requirements applicable to the item or service in question.

Plans are required to develop an online consumer price tool that features real-time data, is updated timely and accurately, allows for consumers to search data by in- and out-of-network providers, billing codes, or descriptive terms. Beneficiaries would also be held harmless for any costs paid that exceed price estimates generated by the online tool.

Beginning Jan. 1, 2027, health plans must submit publicly available monthly rate and payment reports to the Exchange, HHS, and states. These reports must disclose in-network rates for providers and services, the in-network rates and historical net prices paid for covered prescription drugs, and out-of-network data on costs billed by providers and allowed by plans. Monthly disclosures are required to be submitted in three machine-readable files, separated by in-network costs, prescription drug pricing costs, and out-of-network costs. HHS is instructed to promulgate guidance requiring that such files must be widely available, easily and freely accessible, and limited in size. Rates and prices disclosed in these files must include pricing formulas and calculations, plain language descriptions of items/services, billing codes, provider identifier numbers, group health plan identifier numbers, and the site of service.

A senior health plan executive is required to attest to the accuracy and completeness of each disclosure. HHS and the Department of Labor are both granted annual auditing authority, of which the findings and corresponding enforcement actions must be reported publicly to Congress. This section also applies to Accountable Care Organizations participating in the Medicare Shared Savings Program. Upon identifying noncompliance in annual audits, HHS must notify noncompliant health plans with a request for corrective action. Plans that fail to comply with these requests within 90 days are subject to civil monetary penalties up to the lesser of \$300 per member, per day, or \$10,000,000.

- Consumer disclosure requirements effective Jan. 1, 2026. Plans must compile monthly price data reports beginning Jan. 1, 2027.

Sec. 7 – Increasing Group Health Plan Access to Data

Sec. 7 amends requirements for reasonable plan contracts under the Employee Retirement and Income Security Act (ERISA) to mandate access to claims and encounter data for plan fiduciaries. This section allows plans to comply with applicable law and verify the accuracy of payments made to contracted providers. Access to data may not be unreasonably delayed or limited in scope. This

section limits contractual restrictions, or gag clauses, on the disclosure of information regarding value-based payment arrangements and formulas, the disclosure overpayments and overpayment recovery terms, the right for plan sponsors to select auditors and investigate suspect claim payments, the disclosure of claims processing fees, and the disclosure of de-identified or aggregate information. Covered service providers and group health plans must comply with the Health Insurance Portability and Accountability Act (HIPAA) in disclosing and receiving data. Data disclosed must follow HIPAA transaction standards. The Department of Labor may impose civil monetary penalties of up to \$10,000 per day on providers, provider networks, third party administrators and pharmacy benefit managers, and other service providers that violate this section. Group health plans and issuers must attest annually to availability of required pricing data, and to the accessibility of contract terms and auditing capabilities. Such attestations may not be delegated to third-party administrators.

- Effective for plan years beginning one year after the date of enactment.

Sec. 8 – Oversight of Administrative Service Providers

Sec. 8 amends ERISA and the Public Health Service Act by implementing additional reporting and transparency requirements for administrative service providers contracted with both ERISA and non-Federal governmental group health plans. Administrative service providers include third party administrators, pharmacy benefit managers, provider networks, and relevant subcontractors. Under this section, administrative service providers are required to disclose, on a quarterly basis, information to group health plans including methodologies used to determine reimbursement, the total amount of rebates, fees, alternative discounts, and remuneration received by service providers for claims and administrative services, and payment data regarding alternative compensation arrangements such as accountable care organizations, value-based programs, capitation arrangements, and performance payments.

As with Sec. 7, all disclosures must comply with HIPPA privacy and data interoperability requirements. Service providers and plans are not required to enter into a data sharing agreement. The Department of Labor and HHS are granted enforcement authority over ERISA and self-funded non-Federal group plans, respectively. Failure to comply with these provisions carry a civil monetary penalty of up to \$100,000 per day for each violation.

- Effective for ERISA plan years beginning two years after the date of enactment, one year after date of enactment for self-funded, non-Federal governmental group health plans.

Sec. 9 – State Preemption Only in Event of Conflict

Secs. 2 through 5 will not supersede state transparency and reporting requirements unless such state requirements prevent or hinder the implementation of the Act. ERISA-governed health plans and federal ERISA preemption rules are unaffected by this section.

Sec. 10 – Requirement for Explanation of Benefits

Sec. 10 strengthens existing Explanation of Benefit (EOB) requirements for group health plans by mandating the inclusion of plain language descriptions of items and services with relevant billing codes in estimated costs for emergency services. It amends ERISA, the PHSA, and Internal Revenue Code to ensure continuity across all health plans. Within 45 days of receiving payment requests, plans

must issue an EOB to enrollees electronically or by mail. Such EOBs must include plain language descriptions of a provider's/facilities network participation and an itemized breakdown of each item or service, including applicable billing codes, the amount covered by the plan, related beneficiary cost-sharing levels, amounts accrued towards deductibles, and the site of service. EOBs may be provided in conjunction with notices of claim determination.

- Effective for plan years beginning Jan. 1, 2026.

Sec. 11 – Provision of Itemized Bills

This section adds a new requirement for health providers and facilities to provide patients with itemized bills following a request for payment. Providers must offer the itemized bill within 30 days of receiving the final payment. Each itemized bill is required to include a plain language description of each item or service, applicable billing codes, the price (and billed amount if different) for each item/service provided, and payments already made by or on behalf of the patient. Itemized bills must also disclose information on available language assistance services, contact information from the providing facility or individual for further questions regarding billing, and information about a provider or facility's charity care policies.

Providers and facilities may not take collections actions against a patient unless the provider has complied with all itemized billing requirements, and as long as the bill does not exceed the amount previously disclosed under the good faith estimates required by federal transparency regulations. An exemption is made for additional items and services if a provider documents such as medically necessary due to unforeseen complications or patient-initiated change. The burden of proof for justifying such charges also rests with the provider. HHS may impose penalties on providers and facilities that fail to comply, up to \$10,000 for each instance.

Current Standing:

[H.R. 5582](#) – Referred to House Ways and Means, Energy and Commerce, and Education and Workforce Committees (9/26/2025).

- 10 cosponsors (as of 3/26/2026)

[S. 2355](#) – Referred to Senate Committee on Health, Education, Labor, and Pensions, hearings held. (3/19/2026)

- 18 cosponsors (as of 3/26/2026)