Summary of House and Senate Healthcare Price Transparency Legislation

As of July 30, 2026

American Hospital Association™
Advancing Health in America

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
	Health Care Price Certainty for All Americans Act (H.R. 9645) **Passed out of Full Committee on July 15 (25-15)** **AHA Statement**	**Lower Costs, More Transparency Act (H.R. 9393)** **Passed out of Full Committee on July 21 (45-0)** (Markup convened on July 20) **AHA Statement**	**Patients Deserve Price Tags Act (S. 2355)** **Passed out of Full Committee on July 22 (21-1)** **AHA Statement**	**Health Data Access, Transparency, and Affordability Act (H.R.9228)** **Passed out of Full Committee on June 25 (18-15)**
Hospitals: Reporting Requirements				
• Publicly post machine-readable files in a standardized format with five types of "standard charges": Gross charges, Payer-specific negotiated rates, De-identified minimum and maximum rates, discounted cash prices. • The standardized format includes: - Hospital name, license number, location name, address under single hospital license - File version and date of most recent update - Descriptions of items/ services (both inpatient and outpatient) - Standard charges	Sec. 2 • Must post a plain language description of each item or service accompanied by its code or identifier, as well as all gross charges, payer-specific negotiated charges, de-identified maximum and minimum payer-specific negotiated charges and discounted cash prices or the median cash price charged over the last three years to self-pay patients. • Provide a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining prices.	Sec. 101 • Must post a plain language description of each item or service accompanied by its code or identifier, as well as all gross charges, payer-specific negotiated charges, de-identified maximum and minimum payer-specific negotiated charges and discounted cash prices or the median cash price charged over the last three years to self-pay patients. • Provide a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining prices.	Sec. 2 • Must compile and publish in plain language the standard charges for items and services in both a machine-readable file (MRF) and consumer-friendly format. This includes gross charges, discounted cash prices, payer-specific negotiated charges with third-party payers, facility fees and additional information to aid consumers. • Begins Jan. 1 of the year that begins on or after the date that is one year after the date of enactment for the legislation.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Hospitals: Reporting Requirements (Continued)				
- Standard charge methodology - Accounting or billing codes - Accuracy and completeness statement - Modifiers (description, change) - Prescription drug unit, measurement (among other Rx data) - The name of the hospital leader responsible for overseeing and attesting to the machine-readable file's completeness and accuracy - NPI number(s) • Provide patients an out-of-pocket cost estimator tool OR a shoppable service spreadsheet with payer-specific negotiated rates for 300 services (70 required by CMS). • Update public website root folder .txt file to include: - Machine-readable file URL - Machine-readable file source - page URL - Hospital location - Point of contact • Sign an accuracy and completeness attestation.	• Provide any other additional information the HHS secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service. • HHS secretary is tasked with establishing uniform methods and formats for these disclosures by Jan. 1, 2028.	• Provide any other additional information the HHS secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service. • HHS secretary is tasked with establishing uniform methods and formats for these disclosures by Jan. 1, 2028.	• Provide any additional information the HHS secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges for an item or service. In the case of standard charges for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information shall be made available as determined appropriate by the HHS secretary. • HHS secretary is tasked with establishing uniform methods and formats for these disclosures.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Hospitals: Machine Readable Files Requirements				
• Must post all standard charges, including the following data for negotiated rates that are based on an algorithm: - Median allowed amount - 10th percentile allowed amount - 90th percentile allowed amount - Total number of all allowed amounts - Updated annually.	Sec. 2 • Must post all the hospital's standard charges. • Updated annually; HHS secretary discretion to do so more often.	Sec. 101 • Must post all the hospital's standard charges. • Updated annually; HHS secretary discretion to do so more often.	Sec. 2 • Must post all the hospital's standard charges in a MRF (or a successor technology specified by the HHS secretary). • Updated quarterly if there have been changes to the standard charges.	
Hospitals: Shoppable Services Requirements				
• Must provide information on at least 300 shoppable services, 70 of which are required by CMS. • Price estimators may be used for deemed compliance. • Updated annually.	Sec. 2 • Must provide information on at least 300 shoppable services. • Updated annually. • Price estimator tool can be used to meet this requirement only until advanced explanation of benefits, as specified in the No Surprises Act, goes into effect.	Sec. 101 • Must provide information on at least 300 shoppable services. • Updated annually. • Prices are made available in a consumer-friendly format (as specified by the HHS secretary), which may be like any template made available by CMS as of the date of enactment.	Sec. 2 • Must post all the hospital's standard charges in a consumer-friendly format (as specified by the HHS secretary). • Must provide information on at least 300 shoppable services. In the future, all shoppable services will be required. • Price estimator tools may be used but are not sufficient to meet the shoppable service requirements.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Hospitals: Additional Reporting Requirements				
See full list of standard format data elements above	Sec. 2 • Must post discounted cash prices for inpatient and outpatient services or the median cash price charged over the last three years to self-pay patients, in a publicly accessible location in the hospital (as designated by the HHS secretary). • Hospital executives must submit attestations confirming the accuracy of the price information.	Sec. 101 • Make public (annually) each type 2 national provider identifier associated with the hospital or a unit of the hospital. • Make public (annually) ownership and business structure information of entities with a 5% or more ownership interest in a hospital. • Hospital executives must submit attestations confirming the accuracy of the price information.	Sec. 2 • Must disclose ownership information through existing federal requirements but also in a way that prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a hospital impacts operational, financial, or clinical decision-making for the facility. • Requires hospitals to post the amount of any facility fee or other patient charges that would be added to a patient's bill, as well as offer information that might help the patient avoid the charge. • Hospital executives must submit attestations confirming the accuracy of the price information.	
Hospitals: Penalties for Non-compliance				
• Compliance is monitored by CMS, and all audit and compliance actions are publicly posted online. • Hospitals receive warning notices, then corrective action plans (CAP), and civil monetary penalties (CMPs) if they do not abide by their CAP. Hospitals issued CMPs are listed online. • Based on size, hospitals could receive penalties of $300-$5,500/day.	Sec. 2 • Hospital's compliance is reviewed not less frequently than once every three years. • CMPs are imposed for non-compliance if a hospital has not responded to a corrective action plan within 90 days, scaled by hospital size and severity of violations. • The HHS secretary may through notice and comment rulemaking an increase of the per day limitation on CMPs.	Sec. 101 • No time period for audits or number of audits is specified. • CMPs are imposed for non-compliance if a hospital has not responded to a corrective action plan within 90 days, scaled by hospital size and severity of violations. • The HHS secretary may through notice and comment rulemaking an increase of the per day limitation on CMPs.	Sec. 2 • Compliance is monitored by the HHS secretary for all hospitals annually. • CMPs are imposed for non-compliance if a hospital has not responded to a corrective action plan within 90 days, scaled by hospital size and severity of violations. • The HHS secretary may, through notice-and-comment rulemaking, increase the per-day limitation on CMPs.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Hospitals: Penalties for Non-compliance (Continued)				
• CMPs may be reduced by 35% if hospitals waive their right to a hearing.	• For persistent non-compliance, HHS can assess fines of between $1 million and $10 million (depending on the size of the hospital). • Waivers or penalty reductions may be granted under specific hardship or rural access conditions. • CMS will post compliance information to its website, including the number of reviews done, actions taken against hospitals, any waivers granted and any CMPs issued.	• For persistent non-compliance, HHS can assess fines of between $1 million and $10 million (depending on the size of the hospital). • Waivers or penalty reductions may be granted under specific hardship or rural access conditions. • CMS will post compliance information to its website, including the number of reviews done, actions taken against hospitals, any waivers granted and any CMPs issued.	• Extraordinary collection actions against patients are prohibited during periods of noncompliance. • For persistent noncompliance, HHS can assess fines of between $1 million and $10 million (depending on the size of the hospital). • No waiver of CMPs is allowed except when the HHS secretary determines that imposing the maximum CMP will disrupt operations in a manner that impacts patient care.	
Clinical Labs: Reporting Requirements				
	Sec. 2 • Applicable laboratories receiving Medicare payments must, beginning Jan. 1, 2028, publicly disclose discounted cash prices (in a publicly accessible location in the facility as designated by the HHS secretary) or gross charges for specified clinical diagnostic laboratory tests, including ancillary services like specimen collection. • This information must be updated annually and submitted with attestations of accuracy from their executives.	Sec. 102 • Requires applicable laboratories to compile and make publicly available the discounted cash price (or gross charge if no such price exists) for clinical diagnostic laboratory tests included in the list of CMS-specified shoppable services that are furnished by such laboratory. • The price or charge for these specified clinical diagnostic laboratory tests must include the price or charge for any applicable ancillary item or service that would normally be furnished by the laboratory as part of the test.	Sec. 3 • Applicable laboratories must publish quarterly their standard charges for specified clinical diagnostic tests, including gross charges, discounted cash prices, payer-specific negotiated charges, and ownership information. Ancillary services routinely provided with tests must be included in the charges. • Compliance is reviewed annually, with penalties up to $300 per day. • The HHS secretary may, through notice-and-comment rulemaking, increase the per-day limitation on CMPs.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Clinical Labs: Reporting Requirements				
	• The HHS secretary will establish uniform methods and formats for disclosure and monitor compliance through rulemaking, with enforcement provisions including notifications, corrective action plans and CMPs of up to $300 per day for failure to comply. Penalty waivers and reductions are available for hardship scenarios.	• This information must be updated annually and submitted with attestations of accuracy from their executives. • Must make public (annually) ownership and business structure information of entities with a 5% or more ownership interest in a facility. • Noncompliance can result in civil penalties up to $300 per day. No waivers specified.	• Executives must attest to the accuracy of the posted information. • No waiver of CMPs is allowed except when the HHS secretary determines that imposing the maximum CMP will disrupt operations in a manner that impacts patient care. • Must disclose ownership information through existing federal requirements but also in a way that prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a hospital impacts operational, financial, or clinical decision-making for the facility.	
Imaging Services: Reporting Requirements				
	Sec. 2 • Providers and suppliers furnishing specified imaging services under Medicare must, starting Jan. 1, 2028, disclose discounted cash prices (in a publicly accessible location in the facility as designated by the HHS secretary) or gross charges for these services, update information annually and submit attestations from their executives as to the accuracy of the information.	Sec. 103 • Requires providers and suppliers of imaging services not covered under hospital or ambulatory surgical center requirements to make publicly available the discounted cash price (or gross charge if no such price exists) for imaging services included in the list of CMS-specified shoppable services that are furnished by such provider or supplier.	Sec. 4 • Imaging service providers, including independent diagnostic testing facilities and outpatient centers, must disclose quarterly their standard charges for specified imaging services, including payer-specific negotiated charges and ownership details. • Noncompliance results in CMPs of up to $300 per day.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Imaging Services: Reporting Requirements (Continued)				
	• The HHS secretary will develop uniform disclosure formats and monitor compliance with enforcement, including CMPs and provisions for waivers or reductions under certain conditions.	• This information must be updated annually and submitted with attestations of accuracy from their executives. • Must make public (annually) ownership and business structure information of entities with a 5% or more ownership interest in a facility. • Noncompliance can result in civil penalties up to $300 per day. HHS secretary may waive or reduce penalties.	• The HHS secretary may, through notice-and-comment rulemaking, increase the per-day limitation on CMPs. • Executives must attest to the accuracy of the posted information. • No waiver of CMPs is allowed except when the HHS secretary determines that imposing the maximum CMP will disrupt operations in a manner that impacts patient care. • Must disclose ownership information through existing federal requirements but also in a way that prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a hospital impacts operational, financial, or clinical decision-making for the facility.	
Ambulatory Surgery Centers: Reporting Requirements				
	Sec. 2 • ASCs receiving Medicare payments must comply with price transparency requirements beginning Jan. 1, 2028. They must disclose standard charges and prices for items and services, including at least 300 shoppable services, update this information annually and submit attestations from their executives submit	Sec. 104 • Requires ASCs to compile and make public standard charges and prices, including all of the ASC's gross charges, as well as the discounted cash price (or the median cash price charged to self-pay individuals for the previous three years) for services included in the list of at least 300 shoppable services that are	Sec. 5 • Specified ambulatory surgical centers must publish quarterly their standard charges for furnished services, including gross charges, discounted cash prices, payer-specific negotiated charges, and ownership information. • Noncompliance results in CMPs of up to $300 per day.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Ambulatory Surgery Centers: Reporting Requirements (Continued)				
	attestations from their executives as to the accuracy of the information. They must disclose discounted cash prices (in a publicly accessible location in the facility as designated by the HHS secretary). • The HHS secretary will establish uniform disclosure methods and monitor compliance with enforcement mechanisms, including CMPs and provisions for waivers or reductions under certain conditions. • Centers with price estimator tools may be deemed compliant with shoppable service disclosure requirements only until advanced explanation of benefits, as specified in the No Surprises Act, go into effect.	furnished by the ASC. • This information must be updated annually and submitted with attestations of accuracy from their executives. • Must make public (annually) ownership and business structure information of entities with a 5% or more ownership interest in a facility. • Shoppable service prices must be made available in a consumer-friendly format (as specified by the HHS secretary), which may be like any template made available by CMS as of the date of enactment. • Noncompliance can result in civil penalties up to $300 per day. HHS secretary may waive or reduce penalties.	• The HHS secretary may, through notice-and-comment rulemaking, increase the per-day limitation on CMPs. • Executives must attest to the accuracy of the posted information. • No waiver of CMPs is allowed except when the HHS secretary determines that imposing the maximum CMP will disrupt operations in a manner that impacts patient care. • Must disclose ownership information through existing federal requirements but also in a way that prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a hospital impacts operational, financial, or clinical decision-making for the facility.	
Health Plans: Reporting Requirements				
• Insurers and self-insured employers must publish monthly public data files detailing in-network negotiated rates, out-of-network historical allowed amounts, and prescription drug pricing.	Sec. 3 • For plan years beginning Jan. 1, 2029, group health plans and health insurance issuers must provide participants with timely cost-sharing information upon request via self-service tools or alternative disclosures.	Sec. 105 • Requires group health plans and health insurance issuers beginning Jan. 1, 2028, to provide participants with timely cost-sharing information upon request via self-service tools or alternative disclosures.	Sec. 6 • Requires health plans and health insurance issuers to provide participants, beneficiaries, or enrollees with detailed coverage information at enrollment, including in-network rates, out-of-network allowed amounts, cost-sharing liabilities, deductibles,	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Health Plans: Reporting Requirements (Continued)				
• Insurers must also provide a self-service online tool giving members personalized, real-time cost-sharing estimates for all covered medical items and services.	• This includes in-network rates, maximum allowed amounts for out-of-network providers, estimated cost-sharing, accumulated deductibles, frequency limitations, prior authorization requirements and any financial incentives. • Plans must also publicly disclose rate and payment information quarterly in machine-readable formats, including in-network rates and claims data for services and drugs, with annual summaries of trends and payment methodologies. Attestations of compliance and accuracy are required annually, with provisions for accessibility for those with limited English proficiency or disabilities. Sec. 4 • Group health plans and insurers must ensure pharmacies are not restricted from informing enrollees about out-of-pocket cost differentials between plan coverage and cash prices for prescription drugs. Pharmacy benefit managers are similarly prohibited from restricting such communications. The definition of out-of-pocket cost includes deductibles,	• Plans must also publicly disclose in-network rates, average payments, and allowed amounts for services and drugs quarterly in machine-readable files. • Must make public (annually) ownership and business structure information of entities with a 5% or more of ownership interest in a plan. • PBMs must disclose applicable spread price drugs and payment differentials. • Requires annual attestations of compliance by health plan executives. • Requires annual report on use of standards-based application programming interfaces to facilitate access to healthcare price transparency information and the interoperability of other medical information. • Requires a report on the feasibility of plans establishing a "provider tool" to assist in allowing providers access to the same information a plan must provide through its self-service tools for individuals with whom the provider is actively treating at the time of such request. • Requires a report on using health plan data to generate national research on negotiated prices.	frequency limitations, and utilization management requirements through a self-service tool. • Must publish MRFs quarterly with in-network rates, out-of-network allowed amounts, and historical billed and allowed amounts for out-of-network services for all items, services and drugs. • Executives must attest to the accuracy of the posted information. • Ownership information of plans and issuers must be disclosed quarterly.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Health Plans: Reporting Requirements (Continued)				
	copayments, coinsurance, and other expenditures as determined by the HHS secretary. Sec. 5 • Medicare Advantage (MA) organizations and prescription drug plan (PDP) sponsors must report every third plan year, starting in 2028, on healthcare provider ownership and financial arrangements, including incentive payments and recoupments related to providers with financial risk arrangements. • MedPAC is directed to submit a report to Congress on the state of vertical integration in healthcare, including for healthcare providers, pharmacies, PDP sponsors, MA organizations and pharmacy benefit managers. • Requires an annual report on the use of standards-based application programming interfaces to facilitate access to healthcare price transparency information and the interoperability of other medical information. • Requires a report on the feasibility of plans establishing a "provider tool" to assist in allowing providers access to the same information a plan must	• Requires a report on the feasibility of including data relating to the quality of healthcare items and services with price transparency information. Sec. 201 • Requires group and individual health plans and issuers that use prior authorization to submit and publicly post prior authorization transparency data. This data must include lists of all items and services subject to prior authorization, numbers and percentages of requests approved and denied at the initial determination stage, appeal rates, appeal overturn rates by item and service and appeal level, and average/median response times. Sec. 202 • Requires health insurance issuers to submit to HHS and publish consumer-friendly information showing how premium revenue is spent, including the percentage of premium revenue spent on claims, quality-improvement activities and other non-claims and overhead categories, plus the percentages retained by the issuer. MA organizations would be required to publish		

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Health Plans: Reporting Requirements (Continued)				
	provide through its self-service tools for individuals whom the provider is actively treating at the time of such request. • Requires a report on using health plan data to generate national research on negotiated prices. • Requires a report on the feasibility of including data relating to the quality of healthcare items and services with price transparency information.	plan-level revenue, incurred claims, non-claims costs and medical loss ratio-related retained amounts. Sec. 203 • Requires health insurance marketplace websites to post recent data on prior authorization rates and plan overhead and claims costs. Sec. 204 • Requires HHS to update guidance in plain language regarding the disclosure of benefit and coverage information by group health plans, health insurance issuers offering group or individual health insurance coverage, and MA plans. Sec. 205 • Streamlines prior authorization requirements under MA plans by establishing an electronic prior authorization standard to streamline approvals, reduce the time a health plan is allowed to consider a prior authorization request, require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials, and encourage MA plans to adopt policies that adhere to evidence-based guidelines.		

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Health Plans: Reporting Requirements (Continued)				
		Sec. 206 • Requires MA encounter data for items and services furnished in plan years beginning Jan. 1, 2027, to include additional payment and assessment information. This data must include the allowed amount for the item or service and beneficiary cost sharing, including deductibles, copayments and coinsurance.		
Health Plans: Penalties for Noncompliance				
• Plans may be subject to non-compliance penalties of up to $100 per day per affected plan member. • Audits and compliance are done by states; there is no publicly available information on audits or compliance.	• There are no enforcement mechanisms or penalties specified in the bill for health plan compliance, only a requirement for a report by the Comptroller General to review compliance with the provisions and make recommendations on enforcement actions.	• PBMs that do not make the specified disclosures are subject to CMPs of $10,000 per day while the failure is ongoing and $100,000 for each item of false information. • There are no other enforcement mechanisms or penalties specified in the bill for health plan compliance, only a requirement for a report by the Comptroller General to review compliance with the provisions and make recommendations on enforcement actions.	Sec. 6 • At least 50 health plans are to be reviewed for compliance with the law by the HHS secretary, and 250 plans by the Labor secretary. • A health plan that fails to comply with a corrective action plan will be subject to a CMP of not more than the lesser of $300 per member, per day or $10 million. • The HHS, Labor, and Treasury secretaries shall annually issue a report to Congress that includes findings, conclusions, and enforcement actions taken based on audits of the machine-readable files.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Health Plan Access to Data				
			Sec. 7 • Clarifies that group health plans have access to all claims and encounter data. • Contracts between group health plans offered by specified large employers and healthcare providers or service entities must allow plan fiduciaries timely access (within 15 days or less) to all claims and encounter data, including supporting documentation. • Contracts cannot unreasonably limit or delay access, restrict audit rights, or conceal pricing and payment terms. • Data must be provided in a manner consistent with HIPAA privacy regulations. Covered service providers must annually notify participants of these requirements. • Violations may result in CMPs of up to $10,000 per day. • Health plans must attest to compliance with the requirements. • Ownership information of covered service providers must be disclosed. • Plans or issuers cannot delegate the submission of annual attestations to third-party administrators or service providers.	• Clarifies that group health plans have access to all claims and encounter data. • Contracts between group health plans and service providers must allow fiduciaries and designated agents timely access (within 15 days or less) to all claims and encounter data, including supporting documentation. • Defines network service providers broadly, including entities with contracts to provide services to group health plans, but excludes healthcare providers acting solely as care providers. • Data must be provided in a manner consistent with HIPAA privacy regulations. • Violations may result in CMPs of up to $10,000 per day. • Health plans must attest to compliance with the requirements. • Plans or issuers cannot delegate the submission of annual attestations to third-party administrators or service providers.

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Oversight of Administrative Service Providers				
		Sec. 106 • Establishes requirements for health plan service providers, including third-party administrators and pharmacy benefit managers, to disclose detailed information such as contractual methodologies, rebates, fees, and alternative payment arrangements to group health plans and issuers every six months. Contractual provisions that limit timely disclosure are prohibited. • Civil penalties of $100,000 per day apply for violations. • Privacy safeguards consistent with HIPAA and other civil rights laws are mandated.	Sec. 8 • Require health plan service providers to disclose financial, contractual, claims, and ownership-related information to group health plans and health insurance issuers quarterly. • Covered service providers must provide information on how reimbursement amounts are calculated, any provider or supplier remunerations, and all payment data related to alternative compensation arrangements. • Contracts cannot unreasonably limit or delay access, restrict audit rights, or conceal pricing and payment terms. • Data must be provided consistent with HIPAA privacy regulations. • Ownership information of health plan service providers must be disclosed. • Violations may result in CMPs of up to $100,000 per day.	
Advanced Explanations of Benefits (AEOBs)				
• AEOBs are required under the No Surprises Act, but no implementing regulations have been released yet.			Sec. 10 • Requires plans or issuers to provide participants with AEOBs, including good-faith estimates (GFEs) of plan liability with itemized billing codes and descriptions.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Advanced Explanations of Benefits (AEOBs) (Continued)				
			• Participants are held harmless for charges substantially exceeding these estimates except for medically necessary or services furnished for unforeseen circumstances. • Final explanations of benefits must be provided within 45 days of claim decision, detailing payments, cost-sharing, site of service and discrepancies from the AEOB.	
Hospital Billing Requirements				
			Sec. 11 • Healthcare providers and facilities must notify individuals of their right to request itemized bills, including language assistance and charity care information. • Providers cannot bill or collect unless these notices are given and charges align with federal price transparency regulations or GFEs, barring unforeseen changes in medically necessary care. • Penalties of up to $10,000 per violation may be imposed for noncompliance.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Other Provisions				
	Sec. 6 • The bill appropriates $65 million to the HHS and Treasury secretaries, and $35 million to the Labor secretary, for fiscal years (FYs) 2027 through 2032 to support regulation drafting, guidance issuance, enforcement, data collection, and other administrative duties. Annual transparency reports on fund expenditure will be submitted to relevant Congressional committees.	Sec. 107 • From 2029 through 2033, the HHS secretary must annually report publicly on ownership of specified entities, including hospitals, clinical laboratories, imaging providers, ambulatory surgical centers and physician-owned practices with more than 25 physicians, as well as physician practices that are not physician-owned. The reports will include business structure, organization type, number of owners, ownership changes, tax status changes and parent company details, with an analysis of consolidation trends, including horizontal and vertical consolidation among these entities. Sec. 108 • Provides $20 million in implementation funding for purposes of carrying out the provisions of Title I. Sec. 301 • Eliminates the statutory distinction between biosimilars and interchangeable biosimilars, providing that biosimilars are deemed interchangeable with their reference products upon approval.	Sec. 9 • The bill does not supersede state laws on healthcare price transparency unless such laws conflict with its provisions. It preserves state authority over related transparency requirements for hospitals, laboratories, imaging providers, and ambulatory surgical centers, without affecting ERISA plans. Sec. 12 • Includes amendments to ERISA and the Internal Revenue Code to incorporate the new transparency provisions. Sec. 13 • Authorizes appropriations for the Secretaries of Labor and Health and Human Services to implement and enforce the Act starting FY 2026 and subsequent years.	

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Other Provisions (Continued)				
		Sec. 302 • Eliminates the requirement for sponsors of biosimilar applications to conduct assessments of pharmacodynamics, immunogenicity and comparative clinical efficacy studies to support licensure. Sec. 303 • Provides FDA greater discretion to summarily deny citizen petitions when it is determined that the primary purpose of the citizen petition is to delay generic competition. Sec. 304 • Establishes an expedited review and approval pathway for certain over-the-counter (OTC) drugs addressing unmet health needs and directs the Food and Drug Administration (FDA) to maintain a list of promising therapeutic areas for OTC development. Sec. 401 • Includes behavioral and mental health and substance use disorder services as required services offered by community health centers.		

Current Requirements	House Ways & Means Committee	House Energy & Commerce Committee	Senate HELP Committee	House Education and Workforce Committee
Other Provisions (Continued)				
		Sec. 402 • Establishes the Nutrition Education and Chronic Disease Prevention Initiative, which would allow the Health Resources and Services Administration to support the integration of evidence-based nutrition education and counseling into primary care delivery and workforce training at community health centers. Sec. 403 • Provides $250 million for FYs 2027 and 2028 to implement Section 401, and $125 million for FYs 2027 and 2028 to implement Section 402.		