

**AMENDMENT TO THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 9393
OFFERED BY MR. JAMES OF MICHIGAN**

Add at the appropriate place the following new sections:

1 SEC. ____ . REQUIREMENT FOR EXPLANATION OF BENEFITS.

2 (a) PHSA AMENDMENTS.—

3 (1) EMERGENCY SERVICES.—Section 2799A–
4 1(f)(1)(C) of the Public Health Service Act (42
5 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
6 follows:

7 “(C) A good faith estimate of the amount
8 the plan or coverage is responsible for paying
9 for items and services included in the estimate
10 described in subparagraph (B), including a
11 plain language description of each item or serv-
12 ice and all applicable billing codes for each item
13 or service, including modifiers, using standard
14 and commonly recognized billing code sets that
15 are clearly identified.”.

16 (2) EXPLANATION OF BENEFITS.—Section
17 2799A–1 of the Public Health Service Act (42

1 U.S.C. 300gg–111) is amended by adding at the end
2 the following:

3 “(g) EXPLANATION OF BENEFITS.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2026, each group health
6 plan, or a health insurance issuer offering group or
7 individual health insurance coverage shall, within 45
8 days of receiving any request for payment for an
9 item or service under the plan, provide to the partic-
10 ipant, beneficiary, or enrollee (through mail or elec-
11 tronic means, as requested by the participant, bene-
12 ficiary, or enrollee) a notification (in clear and un-
13 derstandable language and utilizing substantially the
14 same format as the advanced explanation of benefits
15 required by subsection (f) to enable comparison) in-
16 cluding the following:

17 “(A) Whether or not the provider or facil-
18 ity is a participating provider or a participating
19 facility with respect to the plan or coverage
20 with respect to the furnishing of such item or
21 service.

22 “(B) An itemized explanation of benefits
23 that includes the following:

24 “(i) A plain language description of
25 each item or service.

1 “(ii) All applicable billing codes for
2 each item or service, including modifiers,
3 using standard and commonly recognized
4 billing code sets that are clearly identified.

5 “(iii) The amount the plan or cov-
6 erage is responsible for paying for each
7 item or service.

8 “(iv) The amount of any cost-sharing
9 for which the participant, beneficiary, or
10 enrollee is responsible for each item or
11 service (as of the date of such notification).

12 “(v) The amount that the participant,
13 beneficiary, or enrollee has incurred toward
14 meeting the limit of the financial responsi-
15 bility (including with respect to deductibles
16 and out-of-pocket maximums) under the
17 plan or coverage (as of the date of such
18 notification).

19 “(vi) The site of each item or service.

20 “(2) FORMAT.—If applicable, the notification
21 described in paragraph (1) may be provided in con-
22 junction with, or as part of, a notice of a claim de-
23 termination or other communication required by sec-
24 tion 2719(a) (42 U.S.C. 300gg–19(a)), or regula-
25 tions thereunder.

1 “(h) REGULATIONS.—The Secretary shall implement
2 this section through notice and comment rulemaking in
3 accordance with section 553 of title 5, United States
4 Code.”.

5 (b) IRC AMENDMENTS.—

6 (1) EMERGENCY SERVICES.—Section
7 9816(f)(1)(C) of the Internal Revenue Code of 1986
8 is amended to read as follows:

9 “(C) A good faith estimate of the amount
10 the plan is responsible for paying for items and
11 services included in the estimate described in
12 subparagraph (B), including a plain language
13 description of each item or service and all appli-
14 cable billing codes for each item or service, in-
15 cluding modifiers, using standard and com-
16 monly recognized billing code sets that are
17 clearly identified.”.

18 (2) EXPLANATION OF BENEFITS.—Section
19 9816 of the Internal Revenue Code of 1986 is
20 amended by adding at the end the following:

21 “(g) EXPLANATION OF BENEFITS.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after January 1, 2026, each group health plan
24 shall, within 45 days of receiving any request for
25 payment for an item or service under the plan, pro-

1 vide to the participant or beneficiary (through mail
2 or electronic means, as requested by the participant
3 or beneficiary) a notification (in clear and under-
4 standable language and utilizing substantially the
5 same format as the advanced explanation of benefits
6 required by subsection (f) to enable comparison) in-
7 cluding the following:

8 “(A) Whether or not the provider or facil-
9 ity is a participating provider or a participating
10 facility with respect to the plan with respect to
11 the furnishing of such item or service.

12 “(B) An itemized explanation of benefits
13 that includes the following:

14 “(i) A plain language description of
15 each item or service.

16 “(ii) All applicable billing codes for
17 each item or service, including modifiers,
18 using standard and commonly recognized
19 billing code sets that are clearly identified.

20 “(iii) The amount the plan is respon-
21 sible for paying for each item or service.

22 “(iv) The amount of any cost-sharing
23 for which the participant or beneficiary is
24 responsible for each item or service (as of
25 the date of such notification).

1 “(v) The amount that the participant
2 or beneficiary has incurred toward meeting
3 the limit of the financial responsibility (in-
4 cluding with respect to deductibles and
5 out-of-pocket maximums) under the plan
6 (as of the date of such notification).

7 “(vi) The site of each item or service.

8 “(2) FORMAT.—If applicable, the notification
9 described in paragraph (1) may be provided in con-
10 junction with, or as part of, a notice of a claim de-
11 termination or other communication required by sec-
12 tion 503 of the Employee Retirement Income Secu-
13 rity Act of 1974 or regulations thereunder.

14 “(h) REGULATIONS.—The Secretary shall implement
15 this section through notice and comment rulemaking in
16 accordance with section 553 of title 5, United States
17 Code.”.

18 (c) ERISA AMENDMENTS.—

19 (1) EMERGENCY SERVICES.—Section
20 716(f)(1)(C) of the Employee Retirement Income
21 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is
22 amended to read as follows:

23 “(C) A good faith estimate of the amount
24 the health plan is responsible for paying for
25 items and services included in the estimate de-

1 scribed in subparagraph (B), including a plain
2 language description of each item or service and
3 all applicable billing codes for each item or serv-
4 ice, including modifiers, using standard and
5 commonly recognized billing code sets that are
6 clearly identified.”.

7 (2) EXPLANATION OF BENEFITS.—Section 716
8 of the Employee Retirement Income Security Act of
9 1974 (29 U.S.C. 1185e) is amended by adding at
10 the end the following:

11 “(g) EXPLANATION OF BENEFITS.—

12 “(1) IN GENERAL.—For plan years beginning
13 on or after January 1, 2026, each group health plan
14 or health insurance issuer offering group health in-
15 surance coverage shall, within 45 days of receiving
16 any request for payment for an item or service
17 under the plan, provide to the participant or bene-
18 ficiary (through mail or electronic means, as re-
19 quested by the participant or beneficiary) a notifica-
20 tion (in clear and understandable language and uti-
21 lizing substantially the same format as the advanced
22 explanation of benefits required by subsection (f) to
23 enable comparison) including the following:

24 “(A) Whether or not the provider or facil-
25 ity is a participating provider or a participating

1 facility with respect to the plan or coverage
2 with respect to the furnishing of such item or
3 service.

4 “(B) An itemized explanation of benefits
5 that includes the following:

6 “(i) A plain language description of
7 each item or service.

8 “(ii) All applicable billing codes for
9 each item or service, including modifiers,
10 using standard and commonly recognized
11 billing code sets that are clearly identified.

12 “(iii) The amount the plan or cov-
13 erage is responsible for paying for each
14 item or service.

15 “(iv) The amount of any cost-sharing
16 for which the participant or beneficiary is
17 responsible for each item or service (as of
18 the date of such notification).

19 “(v) The amount that the participant
20 or beneficiary has incurred toward meeting
21 the limit of the financial responsibility (in-
22 cluding with respect to deductibles and
23 out-of-pocket maximums) under the plan
24 or coverage (as of the date of such notifi-
25 cation).

1 “(vi) The site of each item or service.

2 “(2) **FORMAT.**—If applicable, the notification
3 described in paragraph (1) may be provided in con-
4 junction with, or as part of, a notice of a claim de-
5 termination or other communication required by sec-
6 tion 503 or regulations thereunder.

7 “(h) **REGULATIONS.**—The Secretary shall implement
8 this section through notice and comment rulemaking in
9 accordance with section 553 of title 5, United States
10 Code.”.

11 **SEC. ____ . PROVISION OF ITEMIZED BILLS.**

12 Part E of title XXVII of the Public Health Service
13 Act (42 U.S.C. 300gg–131 et seq.) is amended by adding
14 at the end the following:

15 **“SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED**
16 **BILLS.**

17 “(a) **REQUIREMENTS.**—

18 “(1) **ITEMIZED BILL AND OTHER INFORMATION**
19 **REQUIRED.**—

20 “(A) **IN GENERAL.**—A health care provider
21 or health care facility that requests payment
22 from an individual after providing a health care
23 item or service to the patient shall include with
24 such request a written, itemized bill of the cost
25 of each reasonably expected item or service the

1 health care provider or health care facility pro-
2 vided to the individual, including telehealth vis-
3 its or visits by other electronic means. The
4 health care provider or health care facility shall
5 provide the itemized bill not later than 30 days
6 after the health care provider or health care fa-
7 cility received a final payment on the provided
8 service or supply from a third party.

9 “(B) REQUIRED INFORMATION.—For each
10 item or service provided by the health care pro-
11 vider or facility or for which the health care
12 provider or facility is billing the individual, the
13 itemized bill must include—

14 “(i) a plain language description of
15 each distinct health care item or service;

16 “(ii) all applicable billing codes for
17 each distinct health care item or service,
18 including modifiers, using standard and
19 commonly recognized billing code sets that
20 are clearly identified;

21 “(iii) the price and billed amount, if
22 different, of each distinct health care item
23 or service or if the provider or facility is
24 offering binding, all-in prices for bundled
25 items and services, the total binding price

1 for bundled items and services and billed
2 amount;

3 “(iv) any payments made to the
4 health care provider or health care facility
5 by or on behalf of the individual (including
6 payments by any health plan or insurance)
7 for any health care item or service covered
8 in the itemized bill;

9 “(v) information about the availability
10 of language-assistance services for individ-
11 uals with limited English proficiency
12 (LEP);

13 “(vi) the identification of an office or
14 individual at the health care provider or
15 health care facility, including phone num-
16 ber and email address, that shall be able to
17 discuss the specific details of the itemized
18 statement and be authorized to make ap-
19 propriate changes thereto; and

20 “(vii) information about the health
21 care provider’s or health care facility’s
22 charity care policies and instructions on
23 how to apply for charity care.

24 “(2) COLLECTIONS ACTIONS.—

1 “(A) IN GENERAL.—A health care provider
2 or health care facility shall not take any collec-
3 tions actions against an individual—

4 “(i) for any provided health care item
5 or service unless the health care provider
6 or health care facility has complied with
7 paragraph (1); or

8 “(ii) with respect to any items or serv-
9 ices for which the amount appearing on an
10 itemized bill described above in paragraph
11 (1) exceeds the amount disclosed pursuant
12 to Federal health care price transparency
13 regulations, including part 180 of title 45,
14 Code of Federal Regulations, or provided
15 in a good faith estimate that complies with
16 section 2799B–6 of this Act and section
17 149.610 of title 45, Code of Federal Regu-
18 lations, or another good faith estimate pro-
19 vided by a health care entity covered under
20 this section but not otherwise covered
21 under such section 2799B–6 unless the
22 provider or facility documents that the ad-
23 ditional items or services were medically
24 necessary due to unforeseen complications

1 or a patient-initiated change, and could not
2 reasonably have been anticipated.

3 “(B) BURDEN OF PROOF.—The burden of
4 proof under subparagraph (A)(ii) shall rest with
5 the provider, and absent the documentation de-
6 scribed in such subparagraph, the good faith es-
7 timate shall be binding.

8 “(b) FAILURE TO COMPLY.—

9 “(1) PENALTIES.—The Secretary shall impose
10 penalties on any health care provider or health care
11 facility that fails to comply with the requirements of
12 this section in an amount not to exceed \$10,000 for
13 each instance of failure to comply.

14 “(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—If a health care provider or health care fa-
15 cility fails to comply with the requirements of this
16 section, the presumption shall be that charges were
17 substantially in excess of the good faith estimate (as
18 set forth in section 2799B–6) for the purpose of any
19 patient-provider dispute, including in accordance
20 with section 2799B–7 and regulations promulgated
21 thereunder.
22

23 “(c) REGULATIONS.—The Secretary shall implement
24 this section through notice and comment rulemaking in

1 accordance with section 553 of title 5, United States
2 Code.”.

