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:

SEC. ___. REQUIREMENT FOR EXPLANATION OF BENEFITS.

(a) PHSA AMENDMENTS.—

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

"(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain language description of each item or service and all applicable billing codes for each item or service, including modifiers, using standard and commonly recognized billing code sets that are clearly identified.".

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

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

''(g) EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, within 45 days of receiving any request for payment for an item or service under the plan, provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language and utilizing substantially the same format as the advanced explanation of benefits required by subsection (f) to enable comparison) including the following:

''(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service.

''(B) An itemized explanation of benefits that includes the following:

''(i) A plain language description of each item or service.

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

''(iii) The amount the plan or coverage is responsible for paying for each item or service.

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

''(v) The amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 2719(a) (42 U.S.C. 300gg–19(a)), or regulations thereunder.

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

(b) IRC AMENDMENTS.—

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

''(C) A good faith estimate of the amount the plan is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain language description of each item or service and all applicable billing codes for each item or service, including modifiers, using standard and commonly recognized billing code sets that are clearly identified.''.

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

''(g) EXPLANATION OF BENEFITS.—

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

vide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language and utilizing substantially the same format as the advanced explanation of benefits required by subsection (f) to enable comparison) including the following:

''(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan with respect to the furnishing of such item or service.

''(B) An itemized explanation of benefits that includes the following:

''(i) A plain language description of each item or service.

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

''(iii) The amount the plan is responsible for paying for each item or service.

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

''(v) The amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 503 of the Employee Retirement Income Security Act of 1974 or regulations thereunder.

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

(c) ERISA AMENDMENTS.—

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

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

scribed in subparagraph (B), including a plain language description of each item or service and all applicable billing codes for each item or service, including modifiers, using standard and commonly recognized billing code sets that are clearly identified.''.

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

''(g) EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, each group health plan or health insurance issuer offering group health insurance coverage shall, within 45 days of receiving any request for payment for an item or service under the plan, provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language and utilizing substantially the same format as the advanced explanation of benefits required by subsection (f) to enable comparison) including the following:

''(A) Whether or not the provider or facility is a participating provider or a participating

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

''(B) An itemized explanation of benefits that includes the following:

''(i) A plain language description of each item or service.

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

''(iii) The amount the plan or coverage is responsible for paying for each item or service.

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

''(v) The amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 503 or regulations thereunder.

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

SEC. ___. PROVISION OF ITEMIZED BILLS.

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

''SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED BILLS.

''(a) REQUIREMENTS.—

''(1) ITEMIZED BILL AND OTHER INFORMATION REQUIRED.—

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

health care provider or health care facility provided to the individual, including telehealth visits or visits by other electronic means. The health care provider or health care facility shall provide the itemized bill not later than 30 days after the health care provider or health care facility received a final payment on the provided service or supply from a third party.

''(B) REQUIRED INFORMATION.—For each item or service provided by the health care provider or facility or for which the health care provider or facility is billing the individual, the itemized bill must include—

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

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

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

for bundled items and services and billed amount;

''(iv) any payments made to the health care provider or health care facility by or on behalf of the individual (including payments by any health plan or insurance) for any health care item or service covered in the itemized bill;

''(v) information about the availability of language-assistance services for individuals with limited English proficiency (LEP);

''(vi) the identification of an office or individual at the health care provider or health care facility, including phone number and email address, that shall be able to discuss the specific details of the itemized statement and be authorized to make appropriate changes thereto; and

''(vii) information about the health care provider's or health care facility's charity care policies and instructions on how to apply for charity care.

''(2) COLLECTIONS ACTIONS.—

''(A) IN GENERAL.—A health care provider or health care facility shall not take any collections actions against an individual—

''(i) for any provided health care item or service unless the health care provider or health care facility has complied with paragraph (1); or

''(ii) with respect to any items or services for which the amount appearing on an itemized bill described above in paragraph (1) exceeds the amount disclosed pursuant to Federal health care price transparency regulations, including part 180 of title 45, Code of Federal Regulations, or provided in a good faith estimate that complies with section 2799B–6 of this Act and section 149.610 of title 45, Code of Federal Regulations, or another good faith estimate provided by a health care entity covered under this section but not otherwise covered under such section 2799B–6 unless the provider or facility documents that the additional items or services were medically necessary due to unforeseen complications

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

''(B) BURDEN OF PROOF.—The burden of proof under subparagraph (A)(ii) shall rest with the provider, and absent the documentation described in such subparagraph, the good faith estimate shall be binding.

''(b) FAILURE TO COMPLY.—

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

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

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

accordance with section 553 of title 5, United States Code.''.

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